

**OCCUPATIONAL THERAPY SERVICE
REDESIGN FOR CARE OF THE ELDERLY:
MEASURING UP TO A JOINT FUTURE?**

NADIA AIT-HOCINE

**A thesis submitted as partial fulfilment of
the
Requirements for the degree of
Doctor of Philosophy**

**QUEEN MARGARET UNIVERSITY
2016**

Abstract

Partnership working between Health and Social Care is the Scottish Government's strategy to affect major policy and practice level changes within public services in order to meet the fiscal challenges arising from the ageing demographic profile within our society. The Joint Future Group Report, published by the Scottish Government in 2002, specifically identified the profession of occupational therapy as central to the strategy for public service reform and inspired an inter-organisational occupational therapy service redesign within Lanarkshire. The practice and system service redesign transcended Acute, Primary Care and Local Authority care of the elderly occupational therapy services, introducing measures to promote patient continuity of care at an informational, management and relational level. The aim was to promote longitudinal models of patient care that minimised the incidence of patients being transitioned between occupational therapy services. This PhD adopted a critical realism research approach with a mixed method sequential explanatory research design. The aim was to develop a theoretical understanding of the structural and agential influences at the macro meso and micro levels that gave rise to the service redesign outcomes. The results provided illuminating insights as to the agential and structural barriers to partnership working. Service specific patterns emerged that suggested structural and cultural influences on occupational therapy practice resulted in service specific variation in the ability to deliver on the continuity of care service redesign intentions. The agency of the occupational therapists was explored through mechanism based theorising in order to identify morphogenetic influences (facilitators to change) and morphostatic influences (barriers to change) in engaging in the service redesign measures in practice. The results reflect that the occupational therapists within all three service sectors enacted their agency to preserve their respective pre-existing organisational service structures. These results suggest that the learning strategies and associated behaviours of the participating occupational therapists were not conducive to transformational change. The practical insights of the conditioning power of structure vis a vis the discrete reflexive power of agency outlined within this thesis offers the profession of occupational therapy within public services the means of exploring and conceptualising the complex implications of partnership working.

Key Words: Occupational Therapy, Care of the Elderly, Transitions of Care, Continuity of Care, Critical Realism, Mechanism Based Theorising, Theories in Action, Morphogenesis and Morphostasis

Acknowledgements

I wish to express my gratitude to my supervisor Professor Barbara McPake for her reassuring encouragement, patience, support and guidance throughout this research. Her commitment over the years has literally transcended continents. I am also grateful to Professor Kirsty Forsyth for creating the opportunity for this PhD in collaboration with my employer, South Lanarkshire Council, who has continued to support me throughout the duration of the research. I am especially touched by the altruistic gestures of my managers and colleagues during the last few months of finalising this thesis...thank you all. This research has also been supported by a number of other organisations including the Joint Improvement Team, Scottish Government and the Knowledge Transfer Partnership, Department of Trade and Industry. The financial and academic support in the service redesign created opportunities that would have otherwise not existed and enriched my learning experience. My gratitude extends to NHS Lanarkshire, who aptly, in the spirit of the *partnership* focus of this research, afforded me extended access privileges to staff and resources; a pre-emptive action to our new legally constituted organisational integrated identity of South Lanarkshire Health and Social Care Partnership.

A special thanks is offered to the occupational therapists who participated and shared their experience of the service redesign, which by its transformational intent, was unavoidably professionally challenging. I sincerely hope the experience has offered a new perspective on practice that can, over time, be the catalyst for transformative change within our new integrated partnership arrangement. A special mention to Dr Emma Green (nee Dobson) is conveyed as my work colleague, my PhD companion and friend.

Finally, a momentous note of thanks to my family. I love you.

Contents

Chapter 1: Framing this Research and Thesis

1.1.	Introduction: Situating this Research within a Policy and Professional Context	1
1.2.	Terminology for the Thesis	5
1.3.	Research, Question, Aim and Objectives.....	6
1.4.	Research Approach: Critical Realism	7
1.5.	Overview of Thesis Chapters	8

Chapter 2: Theoretical Position and Research Methodology

2.1.	Introduction	13
2.2.	Locating the Theoretical Perspective: Critical Realism	14
2.3.	Critical Realism: Methodological Pluralism	18
2.4.	Critical Realism: Approach to Evaluation	20
2.5.	Critique of Critical Realism.....	23
2.6.	Research Design and Methods	24
2.6.1.	Stage 1: Description	25
2.6.1.1.	Service Mapping	27
2.6.1.2.	Tracking: Retrospective Case Record Analysis and Time and Motion	28
2.6.1.3.	Service Redesign Planning	32
2.7.	Stage 2: Analytical Resolution	40
2.7.1.	Semi-structured Interviews	43
2.8.	Stage 3: Abduction/Theoretical Redescription	46
2.9.	Stage 4: Retrodution	47
2.10.	Stage 5: Comparison between Different Theories and Abstractions	48
2.11.	Stage 6: Concretization and Contextualisation	49
2.12.	Ethical Considerations	49
2.13.	Insider – Outsider Researcher, Reflexivity and Power	52
2.14.	Respect for Intellectual Property	54
2.15.	Ethical and Research Development Approval	56
2.16.	Critical Realist Evaluations Limitations	57

Chapter 3: Partnership Working - Legislative Drivers and Policy Influences	
3.1.	Introduction61
3.2.	Partnership Working: Demography and Fiscal Challenge Context64
3.3.	Partnership Working: Governing Political Philosophy and Policy Action67
3.4.	Partnership Working: Governance, Performance Indicators and Perverse Incentives73
3.5.	Partnership Working: The Evidence78
3.6.	Partnership Working: Organisational Complexity and Collaborative Tensions81
3.7.	Partnership Working: Transitional Care and Continuity of Care88
3.7.1.	Transitional Care89
3.7.2.	Continuity of Care90
3.8.	Theoretical Critique and Debate: Framing the Partnership from a Sociological Perspective94
3.9.	The Three Dichotomies of Sociological Enquiry95
3.9.1.	Subjectivity and Objectivity95
3.9.2.	Agency and Structure96
3.9.3.	Synchrony and Diachrony98
3.10.	Mechanism and Macro, Meso and Micro Levels of Analysis99
3.11.	Macro – Micro Mechanisms: Street Level Bureaucracy.....102
3.12.	Micro – Macro Mechanisms: Organisational Learning109
3.12.1.	Single-loop and Double-loop learning112
3.12.2.	Theories-in-use: Model I and Model II113
3.13.	Partnership Working: Occupational Therapy in Practice116
3.13.1.	Occupational Therapy Definition and Socio-Historic Summary117
3.14.	Occupational Therapy and the Joint Future Agenda120

Chapter 4: Transitions of Care - Quantitative Data Analysis

4.1.	Introduction	131
4.2.	Background: Pre-service Redesign Transitions of Care profile	131
4.3.	Transitions of Care: Service and Practice Implications	134
4.4.	Occupational Therapy Service Activity: Direct and Indirect Patient Care Activity	136
4.4.1.	Direct and Indirect Service Activity: Implications on Continuity of Patient Care	139
4.4.2.	Direct Service Activity: Assessment, Intervention, Meetings and Communication	139
4.4.3.	Indirect Service Activity: Documentation, Meetings, Communication and Travel	141
4.5.	Service Redesign Measures: Minimising the Incidence of Transitions of Care	148
4.6.	Quantitative Data Analysis: Service Redesign Outcomes	150
4.6.1.	Quantitative Data Analysis: Profile of Complete and Incomplete Test Cases and Impact on the Incidence of Transitions of Care	151
4.6.2.	Quantitative Data Analysis: Outcome on Patient Length of Stay in Service Pre and Post Service Redesign	154
4.6.3.	Quantitative Data Analysis: Range, Frequency and Nature of Occupational Therapy Service Contact Pre and Post Service Redesign	155
4.7.	Quantitative Data Analysis: Exploration of Observed Service Variances across Acute, Primary Care and Local Authority Occupational Therapy Services	159
4.7.1.	Quantitative Data Analysis: Patient Dependency Profiles and Acute, Primary Care and Local Authority Occupational Therapy Service Activity	163
4.7.2.	Quantitative Data Analysis: Acute, Primary Care and Local Authority Occupational Therapy Service Intervention and Patient Dependency Outcomes	166
4.7.3.	Quantitative Data Analysis: Patient Assessed Needs and Occupational Therapy Service Interventions.....	169
4.8.	Quantitative Data Analysis: Concluding Reflections	172

Chapter 5: Service Redesign – the Agency of Occupational Therapists	
5.1.	Introduction174
5.2.	Occupational Therapy Services: Perceptions of Service Redesign Measures174
5.2.1.	Occupational Therapy Services: Perceived Service Focus and Professional Role175
5.2.2.	Occupational Therapy Services: Perceived Service Drivers and Service Outcomes for Patients181
5.2.3.	Occupational Therapy Services: Perceived Outcomes for Informal Carers183
5.2.4.	Occupational Therapy Services: Perceived Service Constraints and Service Facilitators186
5.2.4.1.	Service Constraints186
5.2.4.2.	Service Facilitators194
5.3.	Service Redesign Measures: Occupational Therapists' Reported Perceptions of In-practice Experience198
5.3.1.	Unified Practice Approach: Occupational Therapists' Perceptions199
5.3.1.1.	Occupational Therapists' Perceptions: Modified Barthel Index200
5.3.1.2.	Occupational Therapists' Perceptions: Model of Human Occupation Screening Tool202
5.3.1.3.	Occupational Therapists' Perceptions: Single Shared I.T. Documentation System204
5.3.1.4.	Occupational Therapists' Perceptions: Introduction of Service Coordinator207
5.3.1.5.	Occupational Therapists' Perceptions: In-reach/Outreach Practice Arrangements210
5.4.	Service Redesign: Perceived Impact on Continuity of Care216
5.4.1	Service Redesign: Perceived Impact on Continuity of Care at a Relational Level216
5.4.2	Service Redesign: Perceived Impact on Continuity of Care at a Management Level217
5.4.3.	Service Redesign: Perceived Impact on Continuity of Care at an Informational Level219
5.5.	Service Redesign: Occupational Therapists' Perspectives

	on Full Implementation	220
5.5.1.	Service Redesign: Summary of Perceptions	224
 Chapter 6: Mechanism Based Theorising and Discussion		
6.1.	Introduction	225
6.2.	Situational Mechanism Based Theorising: Macro to Micro Level	226
6.3.	Action-formation Mechanism Based Theorising: Micro to Micro Level	231
6.3.1	Action Formation Mechanisms: Modified Barthel Index and Model of Human Occupation Screening Tool	232
6.3.2	Action Formation Mechanisms: Integrated Information Technology Systems	237
6.3.3.	Action Formation Mechanisms: Unified Management Arrangement	242
6.3.4.	Action Formation Mechanisms: In-Reach/Outreach Practice Arrangement	247
6.4.	Transformational Mechanism Based Theorising: Micro to Macro Level	257
6.4.1.	Transformational Mechanisms: Acute and Primary Care Occupational Therapy Services' Situational Logic	259
6.4.2.	Transformational Mechanisms: Local Authority Occupational Services' Situational Logic	263
6.4.3.	Transformational Mechanisms: Implications for Organisational Learning and Collaborative Working within Acute, Primary Care and Local Authority Occupational Therapy Services	265
 Chapter 7: Conclusion - Reflections and Recommendations for Future Research		
7.1.	Introduction: Revisiting the Critical Realism Research Design and Research Aims	271
7.2.	Research Findings: Inter-organisational Transitions of Care Profile	273
7.3.	Research Findings: From Empirical Observations to Transcendental Reality	274

7.3.1.	Service Redesign Outcomes: Macro Level Organisational Perspective	274
7.3.2.	Service Redesign Outcomes: Meso Level Service Perspective	276
7.3.3.	Service Redesign Outcomes: Structural Conditioning Influences	278
7.3.4.	Service Redesign Outcomes: The Agency of Occupational Therapists	283
7.3.5.	Service Redesign Outcomes: Implications for Partnership Working	288
7.4.	Contribution to Theory, Research and Practice within Occupational Therapy	291
7.4.1.	Unveiling the Epistemic and Ontic Fallacy	292
7.4.2.	Authenticity: The Incongruence of Antecedent Perceptions, Statements of Intent and Action	293
7.4.3.	The Allure of Succumbing to Structural and Cultural Conditioning	294
7.4.4.	The Temporality of Social Transformation	296
7.4.5.	The Counterintuitive Nature of Unintended Consequences	297
7.5.	Considerations for Future Practice and System Development within Occupational Therapy Services	298
7.6.	Recommendations for Future Research	299

References	301
------------------	-----

List of Appendices

Appendix 1a	Staff Information Sheets: Mapping (Intra Service)	324
Appendix 1b	Staff Information Sheets: Mapping (Inter Service)	327
Appendix 2	Visio Maps.....	329
Appendix 3	Time and Motion: Tracking Manual	347
Appendix 4	Semi-Structured Interview Format	384
Appendix 5	Consent Forms	386
Appendix 6	Transcript Example.....	387
Appendix 7	Transcript Analysis	405

Appendix 8	NHS Research Ethics Committee Approval	408
------------	--	-----

List of Figures

Figure 1	Transitions of Patient Care Profile	132
----------	---	-----

List of Tables

Table 1	Description and Comparator of Transitioned and Non Transitioned Patients	135
Table 2	Direct Service Activity Analysis	140
Table 3	Indirect Service Activity Analysis: Documentation	142
Table 4	Indirect Service Activity Analysis: Meetings	143
Table 5	Indirect Service Activity Analysis: Communication	145
Table 6	Indirect Service Activity Analysis: Travel	147
Table 7	Care of the Elderly In-Reach/Outreach Test Cases.....	152
Table 8	Acute ADL Service Activity and Patient Outcome Profile	164
Table 9	Primary Care ADL Service Activity and Patient Outcome Profile	165
Table 10	Local Authority ADL Service Activity and Patient Outcome Profile	166
Table 11	Inter-Organisational Service Intervention and Outcome Profile	171
Table 12.	Data Analysis Extract	189
Table 13	Case Example: Patient X	202

List of Graphs

Graph 1	Acute Occupational Therapy Services: Patient Dependency Levels and Service Intervention Activity Profile	160
Graph 2	Primary Care Occupational Therapy Services: Patient Dependency Levels and Service Intervention Activity Profile	161
Graph 3	Local Authority Occupational Therapy Services: Patient Dependency Levels and Service Intervention Activity Profile	162
Graph 4	Reported Occupational Therapy Service Focus	175
Graph 5	Reported Occupational Therapy Service Primary Roles	176
Graph 6	Occupational Therapy Reported Person Centred Outcomes	182

Graph 7	Occupational Therapy Reported Structural Constraints	187
Graph 8	Occupational Therapy Reported Structural Facilitators	194
Graph 9	Occupational Therapy Perceptions of Service Redesign Measures: Practice Development (MBI/MoHOST)	199
Graph 10	Occupational Therapy Perceptions of Service Redesign Measures: Perceptions to I.T. Measure	199
Graph 11	Occupational Therapy Perceptions of Service Redesign Measures: Perceptions to Management Measure	199
Graph 12	Occupational Therapy Perceptions of Service Redesign Measures: Perceptions to In-reach/Outreach Measure	199
Graph 13	Occupational Therapy Perceptions on the Full Implementation of the Service Redesign	220
List of Charts		
Chart 1	Service Redesign Phased Implementation Gantt Chart	40
Chart 2	Acute Occupational Therapy Service Activity Profile	137
Chart 3	Primary Care Occupational Therapy Service Activity Profile	137
Chart 4	Local Authority Occupational Therapy Service Activity Profile	138

Chapter I: Framing this Research and Thesis

1.1. Introduction: Situating this Research within a Policy and Professional Context.

Scotland's public services are faced with unprecedented challenges arising from a significant transformation of the nation's demographic profile. At the time of undertaking this research, the number of older people was projected to increase by a third over the period between 2006 and 2016, with the number over 65 being expected to rise by 21.3% and those over 85 year olds expected to rise by 37.9%. These demographic projections predicting escalating numbers of older people within society continue. The anticipated increase of the over 65 population is now expected to rise by a further 55% between 2016 and 2036; whilst the number of people over 85 are expected to rise by 149% during the same timeframe (National Records Scotland Office 2014).

These statistical projections indicate an ageing population with increasingly more complex care needs arising from co-morbidities. As a consequence, a corresponding demand for health and social care services is predicted. If the current baseline expenditure of health and social care provision per capita were to be continued, it is estimated that this would require an annual financial investment in health and social care of £1.1 billion by 2016 and £7.5 billion by 2031. This extraordinary projected increase in demand for key public services is paradoxically set against a context whereby central government has been applying, and continues to apply substantial cuts in public spending in response to the UK's current fiscal deficit (Dolphin 2009). The political mandate within the Scottish Government is to contain public service costs through strategic measures to realise service efficiencies within Health and Local Authority services, whilst promoting improvements in the quality of services delivered. (Wilkinson 1997).

Governmental strategies, throughout the decades, such as Community Care, Best Value, Modernising Government, Joint Future, the Efficient Government initiative, the Integrated Resource Framework and Reshaping Care for Older People have all aimed to modernise Health and Social Services to meet the projected costs of care. The Government's vision was, and continues to be, the redesign of services to

create partnership infrastructures that deliver integrated services that are efficient and effective. (Scottish Executive 2004b).

The Government's efforts to improve the efficacy of public services over several decades however continue to fail those people at their most vulnerable (Coleman 2003, Reed et al 2005, Ellins et al 2012). Service systems are portrayed within the literature as poorly organised and overly devoted to dealing with acute, episodic care needs, with an absence of cohesive multidisciplinary care infrastructures to deliver the full complement of services required by the rising number of older people. The delivery of care is often overly complex and uncoordinated and the existing bureaucratic, system-led processes promote multiple transitions between services whereby users of public services are transferred from one service within an organisation to another or/and to other services within other organisations. Existing transitions of care arrangements within and between organisations is recognised as resulting in a waste of resources through service duplication, leaving unaccountable voids in coverage, jeopardising patient safety and contributing to more frequent hospital admissions (Coleman and Berenson 2004).

Despite the increasing frequency and the shortcomings of transitions of care, the health and social policy arenas have not addressed this subject adequately (Schumacher, 2005). Transitions of care is not explicitly referenced as a specific strategic target for action within the Government's public service transformation agendas. The quality of transitions of care is generally acknowledged as having the potential to improve as a by-product of the measures proposed within legislative and policy frameworks. However, the existing silo organisational structures between and within health and social care continue to prevail and the prevalence of transitions of care is on the increase, whilst a growing body of evidence would suggest the quality of service is on the decrease (McLean and Sutton 2008). If transitions of care is the next major quality improvement challenge facing health and social care services internationally, as suggested by Cotter et al (2002) and Reed et al (2005), more emphasis must be given to developing strategies that support service changes to minimise the incidence of transitions of care or improve the quality and efficacy of service within transitions.

This PhD research was inspired by the concepts within the Scottish Executive's Joint Future Group Report (2002), and stimulated by my personal frustration regarding the profession's past inertia in seizing the opportunity heralded within Blom-Cooper's Commission of Inquiry's (1989) recommendations. The Joint Future Group's measures to improve partnership working were of particular interest within this thesis on two counts. Firstly, the strategy identifies my profession of occupational therapy as central to the policy initiative; and secondly, although not specifically defined as a strategic objective, the Joint Future Group Report's emphasis was on minimising or removing the incidence of service discontinuity which arises when patients transition within and between services. The Joint Future Group's strategic measures of single shared assessment, intensive care coordination and integrated equipment and adaptation services were designed to reaffirm person centred care. This was to be achieved by modifying professional and organisational parameters of practice and responsibility to realise continuity of care arrangements within and across services. Measures to promote effective coordination of information and care at the points of interface between professionals, services and organisations were mandated within this policy context. However, the subtleties of obscuring continuity of care as an explicit policy objective can result in insufficient attention being given to the less obvious measurable dimensions therein. As such, the key measures as defined within the strategy were incorporated and operationalised within this research under the conceptual framework of continuity of care. Continuity of patient care at an informational¹, management² and relational³ level as defined by Haggerty et al (2003) became a central focus of this research's enquiry and analysis.

The service redesign being evaluated was implemented within the timeframe of October 2006 and March 2010. It transcended three Health and Local Authority organisational structures and was embedded in the discrete occupational therapy

¹ Informational continuity: The use of information about the patient's medical condition, past treatment, and personal circumstances (including care preferences) to deliver the most appropriate care for each individual/family (Haggerty et al 2003).

² Management continuity: A coherent approach to the management of a health condition achieved via a consistent and flexible management plan that is accepted by all providers and the individual/family (Haggerty et al 2003).

³ Relational continuity: A consistent therapeutic relationship between the individual/family and one or more providers; access at all times to a provider who "knows" the patient/family (Haggerty et al 2003)

services situated within NHS Lanarkshire's primary and secondary care settings and South Lanarkshire Council Social Work services. The research sites included the occupational therapy services for care of the elderly in the Acute setting delivered within two care of the elderly rehabilitation wards within Hairmyres Hospital⁴; the Hairmyres locality based Primary Care occupational therapy service within the Early Supported Discharge Team (ESDT) based in East Kilbride, and the Local Authority based occupational therapy service within the East Kilbride Social Work Local Office. The service redesign introduced measures to support models of longitudinal care in efforts to minimise the incidence of transitions of care. Occupational therapists were facilitated to retain the duty of care responsibility for their patients through the Acute, Primary and Local Authority settings.

Four service redesign measures designed to redress the practice and system barriers to integrated working and continuity of patient care were incrementally implemented. This included a unified evidence based occupational therapy practice approach that transcended the Acute, Primary Care and Local Authority occupational therapy services, establishing an inter-organisational shared approach to patient care. The inter-organisational implementation of the Modified Barthel Index (MBI) and the Model of Human Occupation Screening Tool (MoHOST) supported this service redesign measure by providing a conceptual framework to guide the occupational therapy practice development across all three occupational therapy service sectors. The second service redesign measure was the introduction of a shared IT system. This facilitated data sharing across the service sectors to support the integrated approaches to patient care by creating a service system that supported the efficient retrieval and conveying of patient data. The datasets extended beyond the occupational therapy service specific records to include pertinent extended service related data to inform the occupational therapy service interventions e.g. levels of homecare being provided. The shared IT system also introduced integrated management systems to support the operational management of the service activity within and between the occupational therapy services. The third service redesign measure introduced in-reach/outreach service practice arrangements. This measure underpinned the longitudinal approach to patient care by extending the occupational therapy service duty of care beyond the traditional

⁴ Hairmyres Hospital is a general hospital located in East Kilbride

discrete occupational therapy service structures and encouraged occupational therapists to assume responsibility for patient care across the Acute, Primary Care and Local Authority care pathway. Direct access to the extended range of occupational therapy resources were made available in efforts to operationalise the aspirations of this service redesign measure. Finally, the fourth service redesign measure introduced a service co-ordinator to oversee and support the operational management of the inter-organisational occupational therapy service activity and development.

1.2. Terminology for the Thesis

Within this thesis specific terms have been selected and used for continuity throughout. For clarity these will be explained and justified here to facilitate shared understanding for the reader.

The term patient will be used throughout this research to refer to a person who is in receipt of occupational therapy services across Acute, Primary Care and Local Authority service sectors. It is acknowledged however that different terminology was used within the Health and Local Authority settings participating in this research. The term patient is ordinarily used within the Health sector context, whilst the South Lanarkshire Local Authority service terminology for an individual in receipt of services is service user. This anomaly is reflective and symptomatic of the cultural differences between the Health and Local Authority services exposed within this research. The choice to select the term patient was merely premised on the sequence of care provided to the patient within the context of this research. This ordinarily commenced within the Acute Health based setting. As such, the term patient is only intended as a point of clarity within this thesis.

The terms of in-reach and outreach within the context of this research denotes the practice approach promoted within the service redesign that facilitated longitudinal patient care. This was facilitated by supporting the occupational therapists to extend their duty of care to the patient beyond the traditional service boundaries in terms of practice and location. In-reach practice measures related to the community based occupational therapists (from both the Health based Primary Care services and the Local Authority Social Work based services) assuming responsibility for patients

under their care into the Acute hospital based service when admitted to hospital. The term outreach reflects the practice measure of hospital based occupational therapists extending their duty of care beyond the traditional confines of the hospital setting and supporting the patient's discharge to the community setting. These adjustments to practice were a departure from the pre-service redesign service arrangements which would not have accommodated inter-organisational practice mobility as a practice norm.

The terms Acute, Primary Care and Local Authority occupational therapy services reflect the discrete service sectors in which the occupational therapists are employed. In the interests of clarity, a description as to the intended meaning of each term with regard to the occupational therapy services participating within this research will be provided. Acute denotes hospital based occupational therapists employed within care of the elderly wards; Primary Care services represents the Health community based occupational therapists employed within the Early Supported Discharge Teams specifically and does not include other occupational therapists employed within other Primary Care based services e.g. Rapid Response Team; and Local Authority reflects community based occupational therapists employed within Social Work Services.

1.3. Research Question, Aim and Objectives

The question posed within this research was, what are the facilitators and inhibitors to partnership working in the implementation of a care of the elderly occupational therapy service redesign across Acute, Primary Care and Local Authority services?

The research aimed to understand the outcomes of a practice and system service redesign that sought to minimise the incidence of transitions of care in order to develop a theoretical understanding of the relationship between the measures implemented to promote informational⁵, management⁶ and relational⁷ continuity of care, and the resultant outputs and outcomes in relation to transitions of care. The service redesign measures sought to create inter-organisational service system

improvements and practice changes that minimised the incidence of patient transitions of care, or enhanced the service processes associated with transitions of care, between the occupational therapy services. The service redesign measures introduced promoted continuity of patient care at an “informational”, “management” and “relational” level.

This evaluation research objectives aimed to develop a theoretical understanding of the service redesign outcomes by:

1. Quantifying the empirical service redesign results in terms of organisational outcomes and the outcomes associated with the services delivered to patients.
2. Theoretically describing mechanisms at the macro, meso and micro levels to hypothesise how the observed outcomes arising from the service redesign measures can be explained.
3. Evaluating the occupational therapy services’ capacity for transformational change by describing the underlying mechanisms and exploring the reproductive or transformational influences of these within a Health and Social Care policy context.

1.4. Research Approach: Critical Realism

Critical realism is aptly described by McEvoy and Richards (2006), as an innovative philosophical perspective that combines a realist ontology with a relativist epistemology in what is described as a form of "robust" relativism. The inherent advantages of adopting a critical realist approach in evaluation research are considered by the authors as being of particular benefit in both theory-driven programme evaluation and policy evaluation. This PhD research adopted a formative evaluation approach and a sequential explanatory research design that embraced the ethos of critical methodological pluralism within a realist ontology (Creswell and Plano Clark 2007). My choice in underpinning this policy evaluation research from a critical realism ontological position is premised on the paradigm's ability to overcome some of the attribution limitations associated with positivist and constructivist approaches. Crucially, realists believe in transcendental reality i.e. analytically distinguishing between the “empirical” (observable phenomena – those

aspects of reality that can be experienced either directly or indirectly), the “actual” (events that take place/those aspects of reality that occur, but may not necessarily be experienced) and the “real” domains (underlying structures, processes and mechanisms- ‘deep’ structures and mechanisms that generate phenomena) (Bhaskar 1978).

The potential of the critical realism approach to uncover micro level theory was particularly appealing within the auspices of this research as the objective was to connect the perceptions held of the world by the occupational therapists in the implementation of the service redesign to the world of observable events. Critical evaluators conceive that initiatives work through the actions of the participating agents exercising their discretion in the choices they make within the context they are situationally positioned (Carlsson 2003).

To date there is a dearth of papers relating to the modernisation of occupational therapy services in the context of the Health and Social Care partnership working policy framework that have an ontological and epistemological perspective derived from the critical realism research paradigm. The value of critical realism is promoted by Pawson and Tilley (1997) as resting in its capacity to reveal both the external theory of a programme (the outputs and outcomes of interventions) and also the internal theory (how the intervention produces the outputs and outcomes) This facilitates an explanatory dimension to the research process that can report on programmes of change in terms of what worked and why, the intended and unintended consequences of change and the extent to which the results have external validity (Birckmayer and Weiss 2000).

1.5. Overview of Thesis Chapters

Chapter 2 introduces the ontological and epistemological position of the research; that of critical realism, and more specifically provides an overview of the research context, the pre and post service redesign research design and the triangulated mixed methodology adopted. The ethical considerations within the auspices of the research are also presented inclusive of matters with regard to intellectual property. Considerations of insider-outsider researcher reflexivity are considered, and finally

an overview of the acknowledged limitations of the emergent research approach in practice concludes this chapter.

Chapter 3 commences by providing an overview of the literature that highlights the unprecedented demographic and fiscal challenges facing public services, with a specific emphasis on health and social care within Scotland. The central government's philosophical and strategic policy action to drive performance in line with the public service modernisation programme is outlined. The associated governance infrastructures mandated by central government are considered, as are the counterintuitive consequences of these on workforce behaviour which is reflected in the review of the empirical evidence on inter-organisational partnership working arrangements.

The subsequent section builds on the empirical evidence that suggests that forging organisational collaborative partnerships are problematic and often fail to meet the intended aspirations (Meschi 1997, Sterna and Green 2005). Within this context, organisational complexity and collaborative tensions are considered and factors that energise or constrain partnership working in terms of structural and agentic variables within a complex stratified organisational context is then deliberated. Patient transitions of care and continuity of patient care, concepts closely affiliated and embedded within the partnership/integration policy framework are also considered within this thesis and are reflected within the literature as a theme that serves to enlighten this thesis' perspective on investigation.

A theoretical critique and debate follows in which the partnership working challenge is framed from a sociological perspective, considering the three dichotomies of social enquiry; that of subjectivity and objectivity, agency and structure and synchrony and diachrony. Gidden's (1984) theory of structuration and Archer's (1995) morphogenetic cycle are central to the sociological deliberation within this critique, and serve to enrich the understanding of the ontological and epistemological position adopted within this research. The centrality of mechanism based theorising at the macro, meso and micro levels is presented as fundamental in the process of critical realism analysis on the understanding that social regularities cannot be exclusively explained by empirical observations (Bhaskar

1975, Pawson 1989). The centrality of mechanisms as an analytical conduit that runs from macro across to micro is reflected in explaining the effects of organisational socialisation; a key consideration within this thesis. Lipsky's (1980, 2010) theory of the 'Street Level Bureaucrat' and Argyris and Schon (1974) theory of individual and organisational learning are presented to offer a theoretical consideration of the relationship between the macro and meso-level structural influences and the agency of micro-level agents.

The final section within chapter 3 considers the literature within the profession of occupational therapy and positions the profession's relatively unique standing as the only profession employed in significant numbers within health and social care organisations as instrumental in the theoretical exploration of partnership working. Firstly, occupational therapy is defined and a brief socio-historic context as to the profession's employment within both health and social care authorities is described and the conceptual values and principles to which occupational therapy affirms its allegiance is considered. Exploring the identity of occupational therapy in this thesis is important to inform the exploration of the agent, structure interface. The profession's locus within the contemporary central government modernisation programme, with a specific emphasis on the Joint Future agenda is explored and a theoretical reflexion regarding the inherent capacity and limitations of the uniquely positioned occupational therapy profession to transcend the health and social care organisational divide to achieve the efficacy aspirations sought by the policy context is considered.

Chapters 4, 5 and 6 aim to present the results in accordance with the ontological and epistemological stance of critical realism and the analysis is stratified to achieve causal comparability. The focus of chapter 4 is to present the quantifiable research data that provides a pre and post service redesign occupational therapy service context from which questions as to the potential underlying causal mechanisms can be posed. This exploration aims to further our understanding of the interplay of structure and agent on the redesign outcomes.

Chapter 5 presents the qualitative based data, introducing the cognate reasoning of the occupational therapists in contexts. This chapter explores the underlying cognitive mechanisms that generate the observable tendencies illustrated in the

Chapter I: Framing this Research and Thesis

empirical data analysis within chapter 4. The emphasis is on the interrelationship of the occupational therapists, as agents, interacting within the pre-existing service structures whilst responding to the structures introduced through the service redesign measures that aimed to minimise the incidence of transitions of patient care.

Chapter 6 further develops the mechanism based theorising approach adopted within this thesis and presents potential explanations with regard to the observed causal tendencies observed within the auspices of the service redesign. The analysis of the relationships is explored by emphasising the synergy and contrasts between the occupational therapists' espoused theories at the empirical level and their actions as evidenced at the actual level. Argyris and Schon's (1974) theories of action is introduced to explain this deviation. The stratified mechanism based theorising within this research is presented in accordance with Hedstrom and Swedberg (1998) classification of mechanisms i.e. situational, action-formational and transformational, and is complemented by Archer's (1995) conceptualisation of situational logics to explain the prevailing defensive reactions observed within the Acute, Primary Care and Local Authority occupational therapy services.

Chapter 7 concludes the thesis by providing an overview of the research findings. The results presented contribute a unique theoretical understanding of organisational change within a policy context of partnership working between Acute, Primary Care and Local Authority occupational therapy services. By maintaining the ontological differentiation between structure and agency, critical realism analytically differentiates between the conditions of action as separable from the occupational therapists' reasoning resulting in the action, thereby facilitating the analysis and evaluation of their interplay at stratified levels of reality. In this way, insight into the conditioning power of structure vis a vis the discrete reflexive power of the occupational therapists offers the profession of occupational therapy within public services the means of exploring the complex implications of partnership working. A set of 5 emerging themes arose from the research to inform the profession of occupational therapy of key considerations when embarking on organisational change in the future. These are presented under the headings of unveiling the epistemic and ontic fallacy, authenticity, the incongruence of antecedent

Chapter I: Framing this Research and Thesis
perceptions, statements of intent and action, the allure of succumbing to structural and cultural conditioning, the temporality of social transformation and the counterintuitive nature of unintended consequences. This chapter concludes with considerations for future practice and system development within occupational therapy services and recommendations for future research.

Chapter 2: Theoretical Position and Research Methodology

2.1. Introduction

This research was one of two PhD projects embedded within a Knowledge Transfer Partnership Project with a focus on a practice and system service redesign within care of the elderly occupational therapy services in Lanarkshire. The funding partner organisations involved in the study were NHS Lanarkshire, South Lanarkshire Council and the Scottish Government Joint Improvement Team, with academic support from Queen Margaret University and the University of Stirling.

This PhD research was engaged in an evaluation of a service redesign within a complex, multifaceted, and politically charged context that spans three organisational structures; namely NHS Lanarkshire Primary Care, NHS Lanarkshire Secondary (Acute) Care and South Lanarkshire Council. The evaluation research was undertaken concurrently to the intervention programme being designed, implemented and developed and assumed a lead in directing the nature, scope and structure of the service redesign programme. The opportunity for this PhD to capitalise on the comprehensive resources made available effectively facilitated the collation of an extended related data set that would not have otherwise been possible. The aim was to understand the outcomes of specific system and practice redesign measures introduced within the three discrete care of the elderly occupational therapy services within these public services (as described in section 1.3.). The service redesign measures sought to create inter-organisational service system improvements and practice changes that enhanced the patient experience of transitions of care within and between the occupational therapy services by promoting “informational”, “management” and “relational” continuity of care. This evaluation research sought to develop a theoretical understanding of the specific service redesign outcomes, by deciphering the underlying mechanisms at play and exploring the impact of these mechanisms on the outcomes of the service redesign within this inter-organisational policy context.

This chapter will introduce the epistemological position of the research; that of critical realism, and more specifically provide an overview of the research context, the research design and the mixed methodology adopted. The ethical considerations within the auspices of the research will also be presented and the

issues of insider-outsider researcher reflexivity will be considered. Finally, an overview of the acknowledged limitations of critical realism as a research approach in practice will conclude this chapter.

2.2. Locating the Theoretical Perspective: Critical Realism

The philosophical assumptions or a theoretical paradigm about the nature of reality are central to understanding the overall perspective from which the study is designed and carried out. A paradigm can be defined as the “basic belief system or world view that guides the investigation” (Guba & Lincoln 1994, p. 105). In the context of research, the paradigmatic positioning relates to the researcher’s ontological and epistemological perspective. The perspective adopted fundamentally orientates thinking, determining the research objective and design and consequently the type of knowledge that is produced.

Traditionally, the paradigmatic split within the social science research community has been between the empirically inclined positivists and the interpretative governed constructivists (Broom and Willis 2007). Wolfe (1997, pp.31), suggests this positivist/constructivist split can be seen as the ‘two faces of the social sciences’. Researchers who subscribe to an interpretivist, constructivist paradigm ascribe to the ontology that knowledge is socially constructed and reality is ultimately subjective (Mertens 2005). Constructivist ontology suggests that there is no objective reality but multiple realities constructed by human beings’ interpretation of a phenomenon of interest. People construct order on the world through cognitive reasoning. This cognitive process is informed by the agent’s pre-existing knowledge and the constructed meaning of a phenomenon is fashioned as information is examined, interpreted, accepted, amended or rejected by the agent. (Krauss 2005).

The constructivist paradigmatic approaches to research is premised on understanding “the world of human experience” (Cohen & Manion 1994, p.36). The objective is to reflect on subjective meanings and interpretation and the social and culturally embedded nature of individual experiences (Rubin and Rubin 2005). The constructivist researcher adopts research methods to elicit “participants’ views of the situation being studied” (Creswell, 2003, p.8), seeking to inductively develop a theory of meaning from subjective experiences and observed patterns in group

behaviour (Creswell, 2003). The intent is not to deduce but rather to induce through the analysis of data that reflects subjective experiences in such a way as to illustrate emerging patterns. The emphasis is also on unveiling the emergence of new results from the data through methodological adjustments to the research design (Sayer 1992, Strauss and Corbin 1998). This methodological flexibility is diametrically opposed to the positivist research approach that insists on a strict research design protocol that restricts the recording of events to only that which is considered as relevant to the testing of pre-existing fixed hypotheses (Broom and Willis 2007). As the constructivist paradigm reasons that knowledge is established through the meanings attached to the phenomena studied; researchers interact with the subjects of study to obtain data; inquiry changes both researcher and subject; and knowledge is context and time dependent (Coll & Chapman 2000, Cousins 2002).

In contrast, the positivist paradigm is based on the rationalistic, empiricist philosophy which maintains that reality is fixed and that objective knowledge can be produced through rigorous methodology. According to the positivist epistemology, the world and the universe are deterministic; they operate by laws of cause and effect that are discernible through the application of the experimental scientific method. The key research method is the experiment which aims to discern natural laws through direct manipulation and observation (Trochim 2000). Positivist science epistemology seeks to explain and predict what happens in the social world by searching for regularities and causal relationships between its constituent elements. Deductive reasoning is used to postulate theories that can be tested.

The positivist approach is thus largely a mechanistic affair (Krauss 2005). Merten (2005) asserts that positivism may be applied to the social world on the assumption that the social world can be studied in the same way as the natural world, i.e. that there is a method for studying the social world that is value free, and that explanations of a causal nature can be provided. This includes an assumption that the collection and interpretation of social facts can be obtained objectively and that unbiased scientific laws or models of behaviour can be produced from these social facts (Bryman 2001, Rubin and Rubin 2005) The dilemma in this presupposition is highlighted by Broom and Willis (2007) as being related to the fact that natural science is not a coherent and consistent entity, and the research methods adopted

within social science have a range of internal conceptual differences in their theoretical foundations. The concept of employing a positivist paradigm within the social sciences is deemed by the authors as problematic. Positivism's rejection of metaphysics holds the position that the goal of knowledge is to observe and measure tangible phenomena and knowledge of anything beyond that is considered impossible (Trochim 2000). The objective within a positivist paradigm is to obtain knowledge through direct observation or measurement and facts are established by breaking down and examining the component parts of a phenomenon.

Critical realism, as a philosophical paradigm, accommodates elements of both positivism and constructivism (Healy & Perry 2000). While positivism believes in a single reality and interpretivism in multiple realities, critical realism subscribes to the ideology of multiple perceptions about a single reality. This concept of reality extends beyond consciousness, but is not entirely distinct or discernible (Healy & Perry 2000). Rather than being supposedly value-free, as in positive research, or value-laden as in interpretive research (Lincoln & Guba 1985), realism is instead "value cognisant" (Krauss, 2005, pp. 761). In accordance with this perspective, Dobson (2002) clarifies the critical realists' ontological position in suggesting that knowledge of reality is socially constructed and as a result cannot be understood independently of the social actors involved in the knowledge derivation; yet, contests the belief that the reality itself is a product of this knowledge derivation process. Critical realism asserts that the reality and the value-laden observation of reality operate in two different dimensions, one intransitive and relatively enduring; the other transitive and emergent (Bhaskar, 1975). The subjective, epistemological (transitive) side of knowledge and the objective, ontological (intransitive) side provides a theoretical perspective that marries an ontological realism with an epistemological relativism, forming an objectivist, yet fallibilist, theory of knowledge (Guba and Lincoln 1994). Critical realist's ontological realism acknowledges there is a real world that exists independently of our perceptions, whilst recognising a form of epistemological relativism that accepts our understanding of this world is inevitably a construction from our own perspectives. Thus, while critical realism rejects the idea of multiple realities, it is attuned to the concept of different perspectives on reality by different individuals and societies, (Maxwell and Mittapalli 2010).

Critical realism espouses a deeply stratified ontology (Bhaskar 1978). Bhaskar's main ideology posits that reality has depth, and that knowledge can penetrate reality to various degrees, though never in totality. Crucially, realists believe in transcendental reality i.e. analytically distinguishing between the empirical (observable phenomena – those aspects of reality that can be experienced either directly or indirectly), the actual (events that take place/those aspects of reality that occur, but may not necessarily be experienced) and the real domains (underlying structures, processes and mechanisms- 'deep' structures and mechanisms that generate phenomena) (Bhaskar 1978). The empirical domain is constituted by fallible human perceptions and experiences of the actual domain which, in turn, is created by events and actions that occur, and are caused, by the innumerable, often obscured or unaccounted mechanisms and conditions that generate the constellation of the real domain. Thus, the causality of a mechanism is contingent on the context in that a mechanism may produce an outcome in one context, and another in a different context.

Realist research attempts to link the underlying structures and mechanisms within the real domain to the observable outcomes at the empirical domain. Researchers observe the empirical domain to discover knowledge of the real world, by naming and describing the generative mechanisms that operate and result in the events that may be observed by a "mixture of theoretical reasoning and experimentation" (Outhwaite 1983, pp. 332). The transformational model of social activity (TMSA) forms the basis of the social scientific investigation in the relationships which operate at the empirical, actual and real domains. Within this model, Bhaskar (1979) posits a duality of structure in which society is necessary for human activity, but, at the same time, is its outcome. As Bhaskar (1979, pp. 215) writes 'Society is both the ever present condition (material cause) and the continually reproduced outcome of human agency; and praxis is both work that is the conscious production and (normally unconscious) reproduction of the conditions of production that is society'. Nonetheless, there is an ontological hiatus between society and persons (Archer 1995). The critical realism approach discerns agency (intentional causality/ transformative praxis) from 'structure' (contextually located social norms, resources, and regulations) and "makes it possible to expose restrictions upon agency that

would otherwise go undetected; and, relatedly, it enables human beings to make more informed, strategic calculations about how to transform the social world in ways that will eliminate such restrictions” (Willmott 2005, pp.758).

However, the effects are not easy to observe because of the effects of the opposing causal mechanisms at play. This manifests in a different view on causality from the positivist’s. The critical realist’s conception of causality differs in that it emphasises demi-regularities and the tendencies of things to occur, as opposed to regular patterns of events. Social science within the critical realist paradigm is an objective empirically based methodological approach which seeks to establish a predictive knowledge of society. However, the supremacy afforded to the pursuit of explanation within this paradigm is a distinctive departure from the positivist approach to research and evaluation. The explanation of a phenomenon is not restricted to instances of well-established regularities. Mechanism based theorising adopted within critical realism approaches supports the discovery of the connections between the phenomena, by unveiling underlying mechanisms at work. “It is only by doing this that the research gets beyond the mere appearances of things, to their nature and essences” (Keat and Urry, pp.3)

2.3. Critical Realism: Methodological Pluralism

The philosophical underpinnings of positivist and constructivist paradigms predispose the research to qualitative or quantitative methodological approaches; the former being more affiliated to that of the constructivist paradigm, the latter being more aligned to the positivist approach to research (MacKenzie and Knipe 2006). While some paradigms may appear to lead a researcher to favour qualitative or quantitative approaches, in effect no one paradigm actually prescribes or prohibits the use of either methodological approach. Indeed, as MacKenzie and Knipe (2006, pp. 199) proclaim, “It is unduly impoverished research, which eschews the use of both qualitative and quantitative research approaches”. Critical realism is a relatively new philosophical perspective that offers a radical alternative to the established paradigms of positivism and constructivism (Houston 2001, McEvoy and Richards 2003). Critical realism sits comfortably with methodological pluralism as the overriding theme is the development, testing and refinement of programme theory.

The stratified ontology of critical realism accommodates both the structural and agential dimensions of reality and subverts the spurious debate between quantitative and qualitative methods, advocating the approach that is considered most appropriate given the research topic of interest and level of existing knowledge pertaining to it (Zachariadis et al 2010). Critical realism is concerned with that combination of both qualitative and quantitative approaches that makes use of the most valuable features of each (Creswell 2003). The test becomes one of determining the most appropriate methodological application to attain the research objectives (Merton & Kendall 1946). Using a combination of quantitative and qualitative methods can however be a methodological 'minefield', because of the complex ontological and epistemological issues that are involved (Blaikie 1991). Difficulties in integrating quantitative and qualitative approaches can be encountered as researchers try to make sense of 'dissonant data' obtained using methods based on conflicting epistemological assumptions (Perlesz and Lindsay 2003, Johnson and Onwuegbuzie 2004). The inherent challenge arises in the task of coherently linking subjective interpretative data with objective quantitative data (Bryman 2004). Researchers need to consider carefully their rationale for using a combination of methods, as there is considerable scope for confusion (Creswell et al 2004). The anti-conflationist position of critical realism predicates the adoption of methodological pluralism only if a common ontological and epistemological position can be sustained (McEvoy and Richards 2006). The anti-conflationist's perspective maintains that it is necessary to distinguish between the logic of justification and the specific methods that are employed.

From a critical realist perspective, the strength of quantitative methods is that they can develop reliable descriptions and provide accurate comparisons that highlight patterns and associations that may otherwise be masked in the exploratory phase of an investigation. Crucially, this can contribute to highlighting new and unexpected causal mechanisms and can test out theories about how causal mechanisms operate under particular sets of conditions (Mingers 2004). The key strength of qualitative methods, from a critical realist perspective, is that they illuminate complex concepts and relationships and promote the emergence of themes during the course of an inquiry that could not have been anticipated in advance.

2.4. Critical Realism: Approach to Evaluation

Evaluation is one of the pillars supporting this research, the other being the epistemological research paradigm of critical realism. This PhD is engaged in an evaluation of a social programme of change applying the tenets of critical realism in the methodology used. The literature covering evaluation is vast, but is dominated by reports of the outcomes of a plethora of different methods of evaluation applied to a wide range of subjects (Clarke 1999). Evaluation in the context of social policies, programmes and interventions has been defined as

“...the systematic assessment of the operation and/or the outcomes of a programme or policy. ... The purpose is the improvement of the programme or policy either by encouraging the elimination of unsuccessful interventions or by giving guidance for how the existing intervention can be modified.” (Weiss 1998b p.320).

Evaluation and research differ primarily in terms of intention. The primary purpose of evaluation is to use existing knowledge in studying effectiveness to support improvements in programme and policy developments; whereas the primary research intention is the discovery of new knowledge. (Clarke 1999). Research, however, underpins evaluation by enabling descriptions of programmes and activities to be developed; explaining relationships between variables or influences; and tracing causal sequences (mechanisms) from one variable to another.

Critical realism carries a profoundly sociological view on social change. Although programme interventions are viewed as being the catalyst that has the potential to promote change, the triggers of change, and to what extent that transformation will hold, are ultimately located in the reasoning and resources of those affected by the programme (Pawson and Tilley 2004). Effects are thus generally produced by and require the active engagement of individuals. Inevitably, the fact that social and public policy is delivered through active programmes to active agents has profound implications for evaluation methodology. Human intentionality is central to the evaluation process. Active programmes only work through the reasoning of people and therefore an understanding of the interpretations of programme participants is integral to evaluating its outcomes. Furthermore, in contrast to the positivist

paradigm approaches, critical realism embraces the fact that programmes of change are injected into open systems and cannot be fully isolated or kept constant. (Pawson and Tilley 2004). Pawson and Tilley (1997) identify a range of external variables which make programmes permeable such as unanticipated events, political change, physical and technological shifts, inter and intra-programme interactions, practitioner learning, organisational imperatives, performance management innovations. These externalities are considered to influence and impact on the delivery of a programme. As a consequence of the unique constellation of these externalities within any given situation, it is argued that the results of a programme cannot be being implemented uniformly. However, Pawson and Tilley (2004) posit that successful interventions can change the conditions that made them work in the first place, and as such, the nature of programmes are regarded as having the potential to be self-transformational.

The stratified and complex nature of partnership working necessitates an evaluation approach that acknowledges and facilitates the exploration of the interplay of both human action and social organisation. Conventional forms of evaluation provide limited understanding, often little more than a simple summary of tangible outcomes. Analysis is restricted to positivistic measurement of outcomes attributed to visible causes via a probabilistic causal model whether using quantitative or qualitative data. The identification of intangible outcomes and generative mechanisms is restricted and as a result, the knowledge to inform programme developments is incomplete. Attempts to enhance the effectiveness and efficiency of interventions drawing upon public resources are constrained by the failure to seek alternative explanations (Jennings 2015).

Interpreting evaluation through a critical realist lens enhances understanding. The layered ontology of critical realism which differentiates between the transitive (real entities which make up the world) and intransitive dimensions (knowledge or models we use to make sense of the real) serves to support techniques of conceptualising and differentiating between contexts and mechanisms in efforts to elicit the generative mechanisms at play that result in the outcomes (Bhaskar 1975). Critical Realism theory based approaches suggest quite micro-levels of mechanisms often relating to human volition, choices and capacities. In these cases, it is the reaction

Chapter 2. Theoretical Position and Research Methodology

of the individual to the measure introduced within a programme that is the mechanism, rather than the specific measure itself.

The critical realism perspective has received increasing interest in organisation and management research, including partnership evaluation (Edwards et al 2014). The critical realism metatheory based evaluation overcomes some of the attribution limitations associated with positivism and constructivism approaches by uncovering micro level theory that facilitates not only the external theory of a programme (what kind of effects certain kinds of interventions can have) but also the internal theory (how the programme produces the outputs), to produce ever more detailed answers to the question of not only whether an initiative works or not, but also *why* an initiative works for *whom* and in *what* circumstances (Carlsson 2003, Pawson and Tilley 1997). This allows the researcher to report on which parts of the programme worked and why, whether they would be applicable to different situations and whether there are any positive and negative effects that would otherwise not be anticipated. (Birckmayer and Weiss 2000).

The complex, stratified system of health and social care delivery arrangements that consists of multiple actors and layers of social processes and structures, required an innovative approach to assessing the impact of the redesign measures introduced that went beyond the simple efficacy question. Critical realism was particularly appealing to exploring and understanding the outcomes of a system and practice redesign on the patient's care within and across health and social care organisations. Realism operates at middle ranges, using concepts that describe interventions at a level of big policy ideas and day-to-day reality of implementation. Pawson and Tilley (2004) situate critical realism as steering a path between making universal claims about what works and focusing on specific measures in specific places relating to specific stakeholders. Critical realism supposes that evaluation can learn lessons from diverse programmes by operation at the middle range. This is on the supposition that change can be induced in relatively few ways; "carrots, sticks and sermons" (Bemelmans-Videc et al 1997) and programme theories repeat themselves from initiative to initiative and from domain to domain. The methodological point of operating at the middle ranges is therefore to capitalise on learning opportunities, but also to realise and transfer the findings of the evaluation. (Pawson 2008)

2.5. Critique of Critical Realism

Critical Realism's focus on the nature of social structure and the character of human agency from a perspective of a stratified ontology i.e. empirical, actual and real, presents methodological implications in social science research (Zachariadis 2013, Kemp 2005). From the ontological assumption that supports the concept of a reality which exists independently of our knowledge of it (intransitive domain) (Bhaskar 1975), critical realism emphasises a philosophical basis to establish the appropriate course for social scientific research. A critical realist account of the ontology of the social world proposes a conceptual framework which, many realists argue, provides appropriate principles by which to regulate research (Kemp 2005).

Kemp (2005), in critiquing critical realism, concedes that in many ways critical realist ontological arguments are convincing within the context of the natural sciences, but qualifies this statement with the caveat that the persuasiveness is dependent on the empirical success of the scientific arguments they are derived from. Furthermore, the author expresses reservations as to the claim put forward by critical realists that the approach should be used to regulate research in the social sciences. The dissention is articulated in terms of the limited evidence to support this assertion and because the concept of "regulation suggests an unjustified foreclosure of research options" (Kemp, 2005 pp 173). Wuisman (2005) supports these misgivings and suggests that social theory would be better served by pluralism and an obligation to defend selected theories and models from critical voices.

Whilst the rejection of the regulation approach per se is acknowledged, Joseph (1998), in defense of critical realism, asserts that a distinction should be drawn between critical realism as a methodological approach from the application of critical realism to regulation theory. Joseph (1998, pp 65) presents critical realism as a "philosophical under labourer" to the sciences and argues critical realism is important because it considers the relation between philosophy and science. His contention is that there is a requirement for a methodological approach which is intimately connected, but not reducible, to the science practice itself. The justification is premised in the belief that if the distinction between science and philosophy is abandoned, the critical scrutiny of science is undermined.

On accepting the potential value of critical realism in providing an interface between the scientific and philosophical, Wuisman (2005) suggests that there is a lack of transparency as to the more practical aspects of doing research within this paradigm. Wuisman (2005), asserts that the critical realism contribution to social sciences would be more productive if the primary modes of logical inference within critical realism (abduction/retroduction) were not analysed within the limited confines of the context of justification, but considered within the much broader framework of scientific discovery. The limitation of the critical realism transcendental argument which asserts the primacy of ontology over epistemology is argued to describe the world from its own substantive theorising. The criticism is that it lacks adequate scientific self-reflexivity (Hedlund-de Wit, 2013).

Wuisman (2005) advocates the combination of deductive (empiricist) and inductive (interpretative) modes of inference with abduction and retroduction (critical realism). The four modes of logical inference are viewed as being of equal importance and contributing distinctive elements to the “cycle of discovery” within social science (Wuisman, 2005, pp.394). As Kemp (2005, pp.176) eloquently concludes the critical realism ontological argument is dependent on “pre-existing scientific research, both to supply the initial premises for transcendental deductions, and to supply valid theories from which valid ontological claims can be derived”. The author continues to proclaim that “Ontology is not setting the agenda and leading empirical research in the natural sciences, but is following behind this research, and requires correction when substantive theories are corrected.”(Kemp 2005, pp.176). The critical realism contribution to social science is thus to explicate the observed events and regularities by unveiling the enduring underlying causal relationships (generative mechanisms). Although instrumental in unveiling deep structures and mechanisms that generate events, critical realism needs to be moderated by recognising the limits of its method (Steele 2005, Hammersley 2009, Sayer 1997).

2.6. Research Design and Methods

Critical realism lacks an established ontology-epistemology-methodology tradition, but the comparatively small number of reported examples applying critical realist perspectives in empirical research is characterised by methodological pluralism (Jennings 2015.). In order to protect the logical coherence of this research,

Danermark et al's (2002) six-stage model for critical realism explanatory research which was utilised in the design of this research. Danermark et al.'s framework is conceptual in the sense that, whilst it is intended to guide practical research to investigate generative mechanisms, it is not intended to establish a rigid process. Rather, the focus is upon developing a valid method, which may involve reiteration and oscillation between steps.

In the exploratory phase of this research, quantitative methods were used to identify patterns and associations that may have otherwise been concealed. The subsequent introduction of the qualitative methods injected the hermeneutic dimension and enriched the analysis to reflect the complex interplay and relationship of underlying generative mechanisms that gave rise to the observable events at the actual level of reality. The extensive range of methodological research tools adopted were designed to provide a rigorous approach to the identification of multiple perspectives on the phenomenon of interest within this research. The coherence of the discrete methodological tools' design and selection was retained through an inter-related process of development (outlined in sections 2.6.1 to 2.6.1.2). The integration of the data, derived from different philosophical assumptions, theories and methods, was exercised through triangulation firmly grounded in abductive reasoning. These actions aimed to promote a rigour to the data collection and analysis within this research and enhance the validity of the representation. Hedstrom and Swedberg's (1998) categorisation of the interrelated situational, action-formation and transformation mechanisms was incorporated to support the mechanism based theorising within this research at a macro-policy level, meso-service level and micro-agential level. The seminal work of Archer (1995) and Argyris and Schon (1974) was also introduced to support the analysis and conceptualisation of agential reasoning and behaviours.

This PhD's application of the Danermark et al (2002) explanatory framework is described below.

2.6.1. Stage 1: Description

Stage one of the critical realist approach to explanatory research described by Danermark and colleagues (Danermark et al 2002) involves detecting and

describing the phenomena to be researched. The objective is to reveal the structure and patterns to describe the situation under study. Miles and Huberman (1994, p. 17) advise that a preliminary conceptual framework about the underlying structures and mechanisms should be developed from the literature and/or from people with experience of the phenomenon, before entering the field to collect data – “ at the outset. . . [develop a] rudimentary conceptual framework”. In accordance with this phase of the explanatory research framework proposed by Danermark et al (2002), the initial premise of this research was to develop an overview of the inter-organisational occupational therapy service activity within and across the organisational boundaries. Quantitative and qualitative methods were used to detect and describe the phenomena as an emergent, descriptive phase within the research study. The primary methods to elicit preliminary data were *service mapping*, the *retrospective case record analysis of patients* in receipt of services and a *time and motion exercise* of occupational therapists practicing within the service. This data collectively quantified the service structures, systems and processes, reflecting the nature, frequency and duration of inter and intra-organisational occupational therapy service interventions. It also provided an insight into the occupational therapists’ perspective as to the value of specific service practice/arrangements and identified the areas considered by the service personnel as requiring development. The analysis of this data served to provide a service redesign baseline with indicative evidence to inform on the system adjustments required within the service redesign. The retrospective case record analysis also served as a post service redesign measure to quantify the service redesign outcomes in terms of patient continuity of care that minimised the incidence of transitions of care. The development and introduction of a complementary intensive qualitative research method in the form of a semi structured interview was similarly informed by the preliminary methodological approach adopted and the empirical findings. The objective of the semi structured interview format was to elicit the views of staff in order to explain and elaborate on the post redesign findings by exploring the perceptions of service practitioners on the service redesign process and outcomes (Tashakkori and Teddlie 1998).

All four data collection formats were peer reviewed by the Knowledge Transfer Partnership Board with representatives from both NHS Lanarkshire, South Lanarkshire Council, Queen, Margaret University, University of Stirling, the Scottish

Government Joint Improvement Team and the Knowledge Partnership. Related unpublished reports were compiled to reflect the baseline evidence and preliminary evaluation outcomes (Ait-Hocine, N., Dobson, E., Forsyth, K., McClymont, J. and Mould G., 2008. *SWITCH Partnership Baseline Evidence and Service Redesign Planning Report*, Edinburgh: Unpublished Joint Improvement Team Scottish Government and Ait-Hocine, N. and Dobson, E., 2013. *Health and Social Care Practice and System Redesign Evaluation Report*, Hamilton: Unpublished South Lanarkshire Council).

2.6.1.1. Service Mapping

The mapping methodology was designed to understand inter and intra occupational therapy service processes and activity as perceived and described by the occupational therapy personnel. In addition, the mapping methodology captured service systems and associated activity (including parallel processes)⁸. A total of 15 workshops were completed across NHS Lanarkshire and South Lanarkshire Council services; 8 focused on service specific pathways within discrete occupational therapy services, i.e. Acute, Primary Care and Local Authority, whilst 7 focused on pathways between Acute & Primary Care services, and Health & Local Authority services. Thirty seven (18 NHS Lanarkshire and 19 South Lanarkshire) occupational therapy staff were identified to represent each service by the occupational therapy heads and team leaders of the respective occupational therapy services. All staff grades were involved to inform the workshop. Where possible, the same occupational therapists attended their respective “area of practice” and then attended the appropriate “interface” workshop related to the geographical locality within which they delivered services. Information sheets (Appendix1) were provided to occupational therapy staff that detailed the structured format for the service mapping exercise.

Staff were facilitated by the researcher, supported by the Knowledge Transfer Partnership Associate to engage in describing the key service processes under the headings of “Referral”, “Allocation”, “Assessment”, “Intervention” and “Discharge/Closure”. An overview of the primary tasks within those systems; the

⁸ Parallel processes includes services which the occupational therapy service are reliant on to deliver services but are not completed by occupational therapy personnel, e.g. administration, technical services., housing, legal services.

documentation and communication arrangements and the accountability structures were considered by the groups, as were the key service drivers in terms of service criteria and service standards. The time allocated to each process within the system was notionally quantified by the therapists, inclusive of the “wait time” patients were required to wait between intra-service tasks and inter- service handover⁹. On completion of the process maps, therapists were asked to participate in an evaluation exercise that considered the current service arrangements with an emphasis on eliciting their perspectives on what steps ‘added value’ to the patient experience; what steps ‘added value’ to the process and what steps were considered wasteful or problematic to staff or patients? (e.g. rework loops, duplication).

All workshops were recorded and the recordings were used to validate the workshop service process maps which were originally documented in session on wall maps and subsequently uploaded onto Visio Maps by Stirling University (Appendix 2). The occupational therapy personnel’s evaluation of the current service arrangements were coded and used to enrich the service process and system related data in eliciting an indicative perceived value placed on the identified service processes and systems by the occupational therapy service personnel. The qualitative findings provided an overview of inter and intra service structures, processes and systems. It also provided an insight into the occupational therapist’s perceptions in respect to professional practice arrangements, service activity and outcomes. The mapping data was subjected to interpretive content analysis and converted to Visio tables¹⁰, reflecting service system processes, time-frames and personnel responsibilities. This data represented the perceived occupational therapy patient pathway within and across Acute, Primary Care and Local Authority settings. The analysed data served to inform the development of the occupational therapy service tracking methodology.

2.6.1.2. Tracking: Retrospective Case Record Analysis and Time and Motion

Tracking methodologies were designed to verify and quantify the actual content, frequency and time of service activity as observed in practice. The tracking

⁹ Inter- service handover relates to transitions of patient care between one occupational therapy service within Acute, Primary Care or Local Authority and another.

¹⁰ Visio: graphic software package

methodologies took two forms; retrospective case record analysis and a time and motion exercise. Both tracking methodologies were undertaken within the Acute, Primary Care and Local Authority occupational therapy services across the NHS Lanarkshire and South Lanarkshire Council organisational boundaries. Two full time research assistant posts were advertised and recruited through competitive interview and selection. This was supplemented by 2 x 0.4 whole time equivalent Queen Margaret University MSc occupational therapy students. These staff/students were employed as research assistants to support the retrospective case record analysis and the time and motion data collection.

Retrospective Case Record Analysis

Firstly, a retrospective case record analysis to track patient/service user pathways within services was completed. This was a direct development of the process maps developed within the facilitated mapping workshops. An Access database was created based on the information gathered from the VISIO-wall maps. The Access database focused on three main sections: demographic details of patients, direct activity provided to the patient and indirect activity provided to the patient. Ninety patients were tracked through retrospective case record analysis. Thirty patients from an Acute care, 30 patients from the Primary Care and 30 patients from the Local Authority services.

The patients tracked were those who had been in the service in January and/or February 2007 or those who had been discharged from the service in January and/or February 2007. Patients were identified from NHS occupational therapy statistical paper based records gathered on a monthly basis by the Acute and Primary Care occupational therapy services for the months of January and February 2007 and through the SWIS electronic system from the local authority for those patients discharged in the months of January and February 2007. An additional time frame was set for the overall length of time in the service for all patients included in the tracking; this was set to a length of stay no longer than six months. Access to OT notes was negotiated through Heads/Team Leaders of services respectively; and the Acute service site access was negotiated through clinical audit and medical records.

The Access database was then used to gather information obtained from patient case records of an occupational therapy episode of care. The Access database was populated by two research assistants, supported by the Knowledge Transfer Partnership Associate engaged in the service redesign implementation and evaluation at both the pre and post service redesign stages. The retrospective case record data was subject to descriptive statistical analysis. The data is presented in chapter 5 through a combination of graphical description and statistical commentary which outlines the pre and post service redesign patient journey through the occupational therapy services. The presented findings evidenced the content and frequency of documented activity per patient in receipt of occupational therapy services within and across Acute, Primary Care and/or Local Authority occupational therapy services i.e. the number of times a patient was seen by an occupational therapist and the nature of the intervention e.g. rehabilitation, equipment and adaptation. The dependency levels of the patient in a range of activities of daily living pre and post occupational therapy intervention was also recorded as was the patient's informal caring situation. The tracking methodology analysis also highlighted the pre and post service redesign service length of stay (LOS) within the respective occupational therapy services, the total number of occupational therapy contacts within and across services, the total number of occupational therapists involved in a patient care pathway and the number of transitions of care between occupational therapy services, including the associated period of time accrued by the patient waiting between services.

Time and Motion

The second tracking methodology implemented was a time and motion study to record observed direct and indirect service activity undertaken by occupational therapy personnel. A standard documentation structure was developed on Excel and uploaded on Samsung personal mobile computers (with stop watch facility). The tracking data gathering tool was designed to investigate the "task time" associated with the "direct" and "non-direct" nature of occupational therapy services to patients within Acute, Primary Care and Local Authority settings. The tool's construction reflected the system structures common to all occupational therapy services as identified within the mapping workshops and verified within the patient tracking study. The system structures were denoted by the categories of "Documentation",

“Communication”, “Assessment”, “Intervention”, “Travel” and “Meetings” (inclusive of consultation and continuous professional development). These categories were subdivided into a further 6 subsets with pre-set drop down options reflecting the permutations specific to the subset category. The category subsets were specifically designed to classify the task being undertaken by the therapist; the method adopted in the execution of the task; the purpose of the task in terms of defining its intent; the quantification of the task time measured in predetermined time intervals, the repetition status of the task i.e. the number of times the same specific task had been undertaken for exactly the same purpose and finally, the outcome of the task which defined the result of the specific task under observation (Appendix 3: Time and Motion Tracking Manual) .

All four research assistants received instruction on the use of the mobile technology and on the data collection schedule format, becoming familiar with the construction and placement on the data entry form. A one day training workshop was followed by 4 days of in-practice sessions that incorporated both independent and paired practice familiarisation/training opportunities for the research assistants within the field. This pilot phase tested the practicality of data entry input and the utility of the tool in collecting the research data in accordance with the predetermined structures. The research assistants were required to download their Excel spreadsheets on a daily basis, logging and reporting any data gathering tool anomalies or tracking issues¹¹. The pilot phase served to provide data to crudely evaluate and analyse inter-rater reliability. The level of agreement at the pre-implementation pilot phase was 74.3% Amendments to the data gathering tool were instigated as a result of the intelligence gleaned from the research assistants and the data submitted on a daily basis. The sample population included 91 therapists across Acute, Primary Care and local Authority services, 78 of whom were observed in practice for a period of one day. The 78 occupational therapy identified staff included all those who were available and excluded those on maternity leave, sick leave and service vacancies.

The research assistants, shadowed identified occupational therapists over the period of ten weeks between 30.05.07 to 13.07.07 for one day and documented the activity on the mobile devices. Telephone and/or e-mail daily contact was

¹¹ Daily reports made to the PhD student.

Chapter 2. Theoretical Position and Research Methodology

maintained with all four research assistants during the data collection phase by the PhD research student. These contacts served to review the daily recordings and address any recording issues to ensure consistency in recording standards. Shared communication in re to any operational updates were sent to the research assistants via e-mail by the PhD student. Opportunities for group discussion were also convened on a regular basis for shared learning and peer support. The quantitative results were downloaded and the time and motion Excel database was subjected to preliminary quantitative analysis through descriptive statistics illustrating the incidence and the time dedicated to the occupational therapy service system processes. Tables, pie charts and graphs to organise and present the data were developed and are presented in chapter 4.

2.6.1.3. Service Redesign Planning

The service redesign planning phase of this PhD's research was an integral element of the Knowledge Transfer Partnership project Services Working to Integrate Therapy into Community Health (SWITCH). The mapping and tracking methodologies undertaken within the auspices of this research provided comprehensive baseline data that evidenced that the health and social care occupational therapy services were operating within silo constructs, driven by organisational priorities. Professional practice was primarily based on 'custom and practice', as opposed to evidence based practice and service activity was dominated by indirect activity, such as documentation, travel and meetings, with limited opportunity for direct patient contact. Communication within and across services presented significant challenges, resulting in services being fragmented, inaccessible and difficult to navigate for patients. Ultimately, patients were recorded as experiencing a high incidence of transitions of care within and across the occupational therapy services, resulting in duplication for both patients and occupational therapy personnel.

The SWITCH Partnership incorporated the PhD's time and motion data to inform the health economic modelling methodologies¹² adopted to simulate the resource implications of service redesign options designed to address the issues identified as

¹² Health economic modelling is defined as the statistical formulation and testing of hypothesised service redesign scenarios on service systems and delivery (Drummond et al 2005)

outlined above. The emphasis was to maximise organisational efficiencies to create service capacity to reinvest in service developments to deliver on service improvements. The organisationally imposed service redesign parameters were that the service redesign would be undertaken within existing resources, and that the redesign options would meet the existing organisational and policy priorities e.g. NHS Delayed Discharge HEAT targets, and Local Authority 28 day assessment service standard. The modelling methodology was complemented by a consultation and option appraisal format to provide a structured approach to facilitate occupational therapy service personnel engagement in understanding and using baseline evidence to facilitate a collaborative decision making process. Occupational therapists were asked to weight a set of criteria relevant to their priority for change. This process of weighting provided *criteria weightings*. The occupational therapy service personnel representatives were then provided with a summary of the baseline evidence and service modelling options and asked to rate each service redesign option against set criteria. This provided *option ratings*. *Criteria weightings* and *option ratings* were correlated through the VISA software¹³ to provide an evaluation of the service redesign options to determine the most efficacious choice.

Patients and carers were also briefed and consulted on redesign options under the auspices of SWITCH. An option rating exercise to elicit the priorities from a service user and carer perspective was undertaken to inform the design of the service redesign to be implemented. A briefing document was provided outlining the baseline data sources and redesign options. The benefits to the patients and carers were outlined. Each patient and carer was asked to prioritise and rate each redesign option from first choice to third choice. The unanimous priority for both occupational therapists and patients and carers was to minimise the incidence of transitions of care for patients. Occupational therapists rated an evidence based practice approach across Acute Primary Care and Local Authority services as the second most critical development; whilst patients and carers considered the I.T. infrastructure developments as a key secondary priority. The third placed option for occupational therapists was the IT development; though this result may have been

¹³ VISA software refers to a decision support tool that enables the comparison of alternative options against multiple criteria.

influenced by the resource investment required¹⁴ vis a vis the prerequisite that the service redesign required to be undertaken within resource. Patients and carers selected the evidence based practice as the third place option for implementation. The service redesign model implemented included the introduction of all three discrete but interrelated service redesign measures. These were as follows:

- (1) A unified evidence based practice approach that transcended the Acute, Primary Care and Local Authority occupational therapy services. This practice approach was embodied and evidenced in the implementation of the Modified Barthel Index¹⁵ (MBI) and the Model of Human Occupation Screening Tool ¹⁶(MoHOST).
- (2) A single shared IT system that facilitated the sharing of information across the occupational therapy services within each of the organisations. The IT solution created an information platform to simultaneously support both the practice and management requirements of the Acute, Primary Care and Local Authority services. Both standardised assessment and outcome measures (MBI and MoHOST) were incorporated within the information system.
- (3) In-reach and outreach occupational therapy practice arrangements that facilitated patient care beyond the traditional organisational boundaries. Therapists were facilitated to continue to support a patient allocated to them either into the hospital from the community setting or follow the patient out to the community once discharged from hospital.

In order to facilitate and support the incremental introduction of the 3 service redesign measures, the Knowledge Transfer Partnership Associate assumed a service coordinator function. The coordinator was an occupational therapist, previously employed within the Acute care of the elderly services within NHS Lanarkshire but appointed through Queen Margaret University in its capacity of lead academic institute within the Knowledge Transfer Partnership Project. The

¹⁴ Weighting criteria measure

¹⁵ The MBI is an ordinal scale used to measure performance in a range of activities of daily living and served to reflect the dependency levels of patients in receipt of the respective occupational therapy services.

¹⁶ The MoHOST is a standardised occupational therapy specific practice applied measure that seeks to explain how occupation is motivated, patterned, and performed through a patient's volition, habituation, and performance capacity

Knowledge Partnership Associate received professional support as the Project Coordinator from the Professional Head of Occupational Therapy Services within NHS Lanarkshire and the Fieldwork Manager¹⁷ for Physical Disability and Sensory Impairment Services from South Lanarkshire Council. This organisational support provided direct access to managers who had devolved authority to make decisions and affect change. The introduction of the service coordinator provided a central integrated resource to support the implementation of the 3 service redesign measures within Acute, Primary Care and Local Authority occupational therapy care of the elderly services. In effect, the service coordinator role and function emerged as the 4th service redesign measure to be implemented and evaluated. This measure is described as follows

- (4) The introduction of a service coordinator to implement a unified approach to the operational management of the occupational therapy services within the research site. This included the provision of practical supports to embed the phased practice and system changes within and between the occupational therapy services, inclusive of direct management responsibilities for the allocation, case management and closure of cases to direct practitioners, irrespective of traditional organisational role.

The introduction of a unified evidence based practice approach that transcended the Acute, Primary Care and Local Authority occupational therapy services was initially introduced. A range of practice development consultation, training events and materials, including individualised in practice learning sessions supported the embedding of the MBI and MoHOST within the occupational therapy services. This learning programme was implemented from October 2006 to March 2010. This measure primarily responded to the management continuity of care objective which places an emphasis on a coherent and consistent approach delivered via collaboration and co-production in care planning and service delivery (Haggerty et al 2003). The imperative was to unite the occupational therapy workforce in a shared vision and practice approach that created an impetus for change and permissions to break free from historical practice priorities and norms to embrace a more patient approach to care. The redesigned whole system shared service priorities were

¹⁷ The Fieldwork Manager position was, at that time, held by the PhD student undertaking this research evaluation.

collectively agreed to reflect the existing discrete organisational imperatives. These were:

1. Safe and timely and discharge from hospital
2. Community focused re-enablement/rehabilitation services
3. Community living support via equipment and adaptations.

These collective shared service priorities directed the whole system service focus, whilst the evidence based practice approach measure aimed to establish a unified practice framework that had the potential to deliver on these by promoting effective patient continuity of care at the management and informational levels. The unified evidence based approach created an inter and intra service potential, whereby the occupational therapy workforce could be equipped with a unified practice approach that supported the standardisation of occupational therapy service input across the Acute, Primary Care and Local Authority service sectors. Although multiple therapists could continue to be engaged in delivering care across the three service sectors, the aim was to foster a sense of continuity in the management of patient care across Acute, Primary Care and Local Authority occupational therapy services. The unified evidence based approach also created a potential to introduce a common professional language that supported the workforce in the effective articulation and documentation of patient details in respect to dependency levels, interventions and outcomes. This created a capacity to share and interpret key patient historic data that informed and directed appropriate future service inputs, effectively promoting informational continuity of care, a prerequisite to continuity of patient care at a management level.

On considering the pivotal nature of the standardised tools' function in providing the structural means to galvanise the occupational therapy practice approach across Acute, Primary Care and Local Authority service, a brief critical overview as to the selected tools' psychometric properties are outlined.

Whilst the validity and the reliability of the Modified Barthel Index is considered to be robust (Leung et al 2007), a study by Collin et al (1988), illustrated scoring differences in half the activities tested i.e. transferring, feeding, toileting, personal grooming and dressing within the original Barthel Index. The authors suggested that

this may have been due to varying levels of skill between the observers. The lack of research evidence demonstrating the inter-rater reliability since the scoring modifications made to the original Barthel Index by Shah et al in 1989 subsequently became an area of occupational therapy professional interest. Authors, such as Eakin (1993) have some reservations as to the MBI's inter-tester reliability, whilst others, such as Fricke and Unsworth's (1996) conclusions suggest that the Modified Barthel Index possesses sound psychometric properties, purporting a level of confidence in the tool's utility within occupational therapy practice.

A psychometric study of the MoHOST undertaken by Kielhofner et al in 2010 concluded that the MoHOST offers practitioners and researchers a valid and reliable measure of volition, habituation, communication/interaction skills, process skills, motor skills, and environmental influences on participation. However, on examining the psychometric properties of the MoHOST, Notoh et al (2013) observed difficulties in the appraisal of some of the patients' abilities within the hospital ward context and concluded with the recommendation that further studies be conducted to establish the utility of the MoHOST for patients with a variety of disabilities and within different contextual settings.

The second key measure was the introduction of a single shared I.T. system that facilitated the sharing of information across the occupational therapy services within each of the organisations. This measure primarily responded to patient continuity of care at an informational level. Effective communication about all care being provided is an essential requirement to deliver the right care at the right time for patients in receipt of services (Haggerty et al 2003). The I.T. solution created an information platform to simultaneously support both the practice and management requirements of the Acute, Primary Care and Local Authority services. In practice terms, the I.T. infrastructure supported the standardisation of the occupational therapy service documentation arrangements that were congruent with the practice developments embodied in the unified evidence based practice approach redesign measure. Both standardised assessment and outcome measures (MBI and MoHOST), inclusive of goal setting and service intervention data, were incorporated within the information system and facilitated the ability to track and measure the nature and impact of the services on patient care across the whole system. Therapists were provided with

classroom and in practice training to develop confidence in utilising the tools within the IT structure. The IT infrastructure also incorporated management data and created an opportunity to identify patients within the whole system, allowing a targeted and focussed approach in the allocation process to avoid unnecessary service duplication.

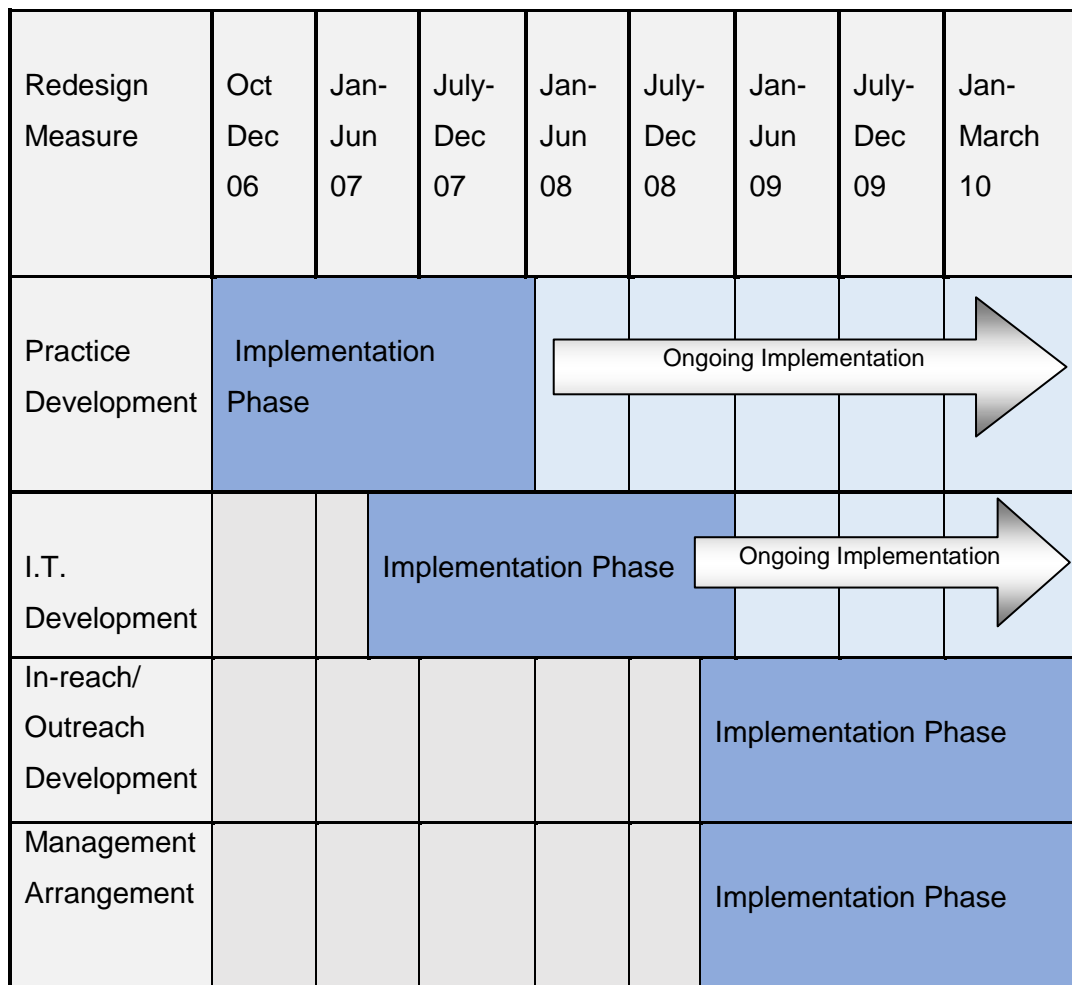
The third key measure introduced was the introduction of a unified approach to the operational management of the occupational therapy services within the research site. The introduction of the service coordinator, who was instrumental in the implementation of both preceding mechanisms (unified evidence based practice approach and unified IT infrastructure), facilitated informed negotiations between service managers across Acute, Primary Care and Local Authority occupational therapy teams. The coordinator's position and knowledge also allowed for the provision of practical supports in the allocation, case management and closure of cases to target practitioners, irrespective of traditional organisational role, on the shared service priorities i.e. timely discharge from hospital; community focused re-enablement services and equipment and adaptations. This management measure further supported the embedding of the unified practice approach and was underpinned by the implementation of the I.T. solution. These 3 measures collectively established the foundation from which the penultimate measure to minimise the incidence of patient transitions of care could be introduced.

The introduction of the in-reach/outreach service redesign measure promoted patient continuity of care at the relational level and removed the need to transition patients between services by extending the occupational therapists' duty of care to beyond the traditional organisational service boundaries. Relational continuity of care requires patients to have a consistent and reliable relationship with one or more providers involved in their care. (Haggerty et al 2003). Occupational therapists within the redesign pilot site were required to adopt an extended duty of care role to assume additional responsibilities in supporting patients through the Acute, Primary Care and Local Authority occupational therapy care pathway. This required Acute hospital based occupational therapists to outreach and follow patients from hospital into the home for re-ablement and/or equipment/adaptation provision; and Primary Care and Local Authority therapists to in reach and assess individuals in the Acute

hospital phase and to support them home with re-ablement and/or equipment/adaptations within the community setting.

The structure to implement the in-reach/outreach mechanism included the creation of “buddying” support arrangements. This included pairing staff from the respective discrete services to support staff to become familiar with new service areas and expected practice norms. In addition, guidance documents were created to provide a reference to outline practice and processes within the different occupational therapy service areas. The staff across all sectors were directed and supported to fulfil the shared service ethos and priorities under the direction of the service coordinator (Measure 3) and were given unique direct access to the unified I.T. system. (Measure 2). In addition, as part fulfilment of facilitating the in-reach/outreach approach and supporting the development of practices that promoted relational continuity of care, occupational therapists were given direct access to an extended range of resources, not normally within their sphere of control e.g. equipment/adaptations. The aspiration was to develop a virtual occupational therapy team within resource that were not bound by historic organisational parameters but were equipped both professionally and structurally to respond effectively to the extended needs of the patient in the care of the occupational therapy service. The service redesign model was incrementally introduced and implemented over a 42 month period as illustrated in the Gantt chart below.

Gantt Chart 1: Service Redesign Phased Implementation



2.7. Stage 2: Analytical Resolution.

This phase is concerned with scientifically analysing the data with the purpose of distinguishing between the various dimensions within and identifying the areas of interest for theoretical enquiry. Analytical resolution is a phase of discernment as it is not feasible to study all of the components; and thus the endeavour is to isolate the subject of specific research interest and focus (Danermark 2002).

In stage two, the descriptor of the phenomenon for study was confirmed as being minimising the incidence of transitions of patient care. This service redesign objective was unanimously perceived as a priority for patients, carers and

Chapter 2. Theoretical Position and Research Methodology

occupational therapists¹⁸. Transitions of care was deconstructed by critiquing literature and the concept of continuity of care was explored as a counteractive measure in minimising the incidence of transitions of care. Continuity of care is summarised by Haggerty et al (2003) as the degree to which a series of discrete care events is experienced as coherent and connected and consistent with the patient's needs and personal context. Three types of continuity exist in all settings: informational, management, and relational. The emphasis on each type of continuity differs depending on the type and setting of care. The focus of this research was transitions of patient care and the process and practice of occupational therapy services considered with a continuity of care lens in the context of a health and social care partnership.

The analysis and findings of the quantitative methodology employed pre and post service redesign i.e. retrospective case record analysis, highlighted paradoxes within the events at the actual level. In summary, the data evidenced that the service redesign model implemented had reduced the incidence of transitions of care for patients across Acute Primary Care and Local Authority occupational therapy services by 44.8%, and as such could arguably have been described as meeting its primary objective. However, from a patient continuity of care perspective, the results were mixed. The analysis reflected positive continuity of care outcomes in terms of patients not having to experience inter-service "wait times" as they transitioned between occupational therapy services. This on average equated to 38 days. The incidence of triplicate assessments was also addressed by the fact that the number of occupational therapists engaged in a single episode of patient care¹⁹ was reduced from a pre redesign average of 3 to a post service redesign average of 1.4. The reconfiguration of the occupational therapy service assessment to intervention ratio was rebalanced from a baseline of 2:1 to 1:4.5, effectively placing an increased emphasis on direct patient care as opposed to patient assessment.

These findings would suggest that the service redesign was successful in meeting a number of continuity of care outcomes, as defined by Haggerty et al (2003), at the

¹⁸ Determined via the occupational therapist option appraisal and patient and carer option rating exercises

¹⁹ Single episode of care within this research refers to the health and social care service continuum arising from the onset of a patient's presentation arising from an incident requiring care to the conclusion of the care.

informational, management and relational levels in terms of the care events being experienced as “coherent and connected”; whether that be evidenced from the direct descriptive statistical evidence or assumed from the anticipated consequences arising from these results. The data analysis, however, also reflected findings that questioned the efficacy of the service redesign measures to promote continuity of care in terms of it being consistent with the patient's needs. The unified evidence based practice approach embodied in the implementation of the MBI and MoHOST tools evidenced that the incidence of assessed unmet need across the Acute Primary Care and Local Authority occupational therapy services equated to 70.3%.

The MBI and MoHOST were introduced as a service redesign measure with the intent of standardising the occupational therapy practice and documentation approach across the service. However, this measure was instrumental in illustrating an inconsistency in occupational therapy practice within the discrete service sectors. A discord was identified between the occupational therapists' espoused commitment to the service redesign measures at the planning stage and their behaviours in practice during their implementation. Service specific patterns emerged from the data that suggested structural and cultural influences on occupational therapy practice that restricted service delivery to service driven practices rather than person centred approaches to care. The practice norms specific to each of the services presented contextual differences that manifested as a variance of 30% to 100% in the respective services capacity to adopt and embed the service redesign measures to minimise transitions of care.

The incongruities of the results in terms of the service redesign delivering on the continuity of care intentions, coupled with the significant variation in the ability of the services to implement the service redesign measures in practice, prompted the expansion of the inquiry to the exploration of potential explanations. The critical realist explanation of programmes such as the service redesign within this PhD research involves an understanding of the mechanisms operating within contexts that produce outcomes (Pawson and Tilley 2007). This requires asking questions of the occupational therapy personnel engaged in the service redesign about their experience of the change process to elicit their perceptions and reasoning that

supports explanations in respect to the patterns of activity within the service redesign programme. For realists, interviews provide access into the stratified accounts of events, experiences and underlying conditions or processes through the attitudes and emotions of informants. For Archer (2003, 2007) the subjective “inner conversations” arising from human reflexivity and reasoning mediates between the interplay of personal concerns (what is valued and important) and the social contexts confronted (the stability or instability of the pre-existing social environment). This shapes the stance taken towards structural constraints and enablers, influencing subsequent interactions which results in either morphostasis (reproduction of the pre-existing social context) or morphogenesis (transformation of the pre-existing social context). Smith and Elger (2014), in their synopsis of critical realist interviewing approaches, promote the exploration of interviewee’s subjective experiences and narrative accounts, but advocate for the use of an appropriate analytical framework to guide questions, frame answers and suggest probes and directions for further discussion. This is critical to Pawson and Tilley’s (2007) conception of theory-led interviews. Furthermore, as advised by Smith and Elger (2014), interviewees’ interpretations need to be subjected to critical analysis by other research sources, including observations, documents and other interviews. The accounts generated by such interviewing should be contextualised in relation to other sources of data, assessed in terms of their comparative adequacy or completeness and on this basis used to test and develop explanatory theories (Smith and Elger 2014).

2.7.1. Semi-structured Interviews

The premise for the interview format within this research was theory driven, but rather than confirming or falsifying a priori theory as Pawson and Tilley (1997) advocate, this research undertook the interview schedule as part fulfilment of the theory generation development. This approach is in accordance with Smith and Elger’s (2014) recommendations which supports the concept of critical realist interviews contributing to theory development as part of the research process. This is viewed as being less likely to create disconnects between empirical data and theoretical analysis. The inherent strength of assimilating the interview as part of the wider research design is that it promotes a temporal cohesion between the researcher’s narrative and the actual agential experience within context.

A semi structured interview format was developed (Appendix 4), incorporating an analytical framework informed by the mapping and tracking preliminary data analysis²⁰ and the structure of the service redesign, which included measures that introduced specific service redesign measures associated with information technology, practice and management arrangements. The analytical framework was embedded in the configuration of the interview structure and sought to access the attitudes and emotions of the occupational therapists on the experience of the service redesign. The semi-structured interview format supported the data collection process by guiding the interviewee through the areas of research interest by means of the content and sequence of the questions. The researcher's knowledge and expertise on the wider context and outcomes of actions facilitated the appropriate use of selective prompts where there was a lack of clarity or where there was merit in elaborating on the initial response provided by the occupational therapist. The semi-structured interview design and approach in practice actively sought to support interviewees to raise issues and express their own perceptions, feelings, meaning, and attitudes in their own words and at their own pace. The expertise of the occupational therapy personnel being interviewed was acknowledged in respect to describing the personal experience of the service redesign in terms of the personal reasoning, choices and motivations (Smith and Elger 2014).

The interview structure created an opportunity for therapists to recount their perspective on the pre-existing service arrangements and on their experience of the service redesign measures in practice. The former accounts sought to glean an insight into the therapists' perspectives on the strengths and weaknesses of substantive services and to define their role there-in. It also aimed to identify potential causal entities through, for example, reported accounts of the cultural and socially constructed practice norms within each of the health and social care service sectors. The occupational therapists' accounts on the service redesign experience covered the thoughts and the value placed on the service redesign measures introduced. This section also invited the occupational therapy practitioners to identify morphogenetic influences (facilitators to change) and morphostatic influences (barriers to change) in engaging in the service redesign measures in practice.

²⁰ Pre-service redesign baseline data

Crucially, the interview format prompted the therapists to reflect on the very personal, micro level account of the impact of the redesign experience on their learning, their practice and their professional aspirations. The significance of eliciting the reflections of the occupational therapists is premised on an understanding that the “inner conversations” are causally efficacious to themselves and to society (Archer, 2003). As such, the power of the inner conversation within this research context influences the extent which the service redesign measures to minimise the incidence of patient transitions of care within the Acute, Primary Care and Local Authority occupational therapy services are successfully, or otherwise, implemented.

All 11 occupational therapists and two service managers with responsibility for NHS Lanarkshire and South Lanarkshire care of the elderly occupational therapy services within the East Kilbride locality, who were engaged in the service redesign were interviewed. The interviews were scheduled over a three and a half week period from the 4th May 2010 to 27th May 2010. Each interview was scheduled for an hour and the duration of the interviews ranged 51 minutes to 1 hour, 17 mins. Informed consent to participate was gained from all the subjects and all interviews were audio recorded on a digital recorder (appendix 5). Transcripts of the interviews were anonymised and written on word documents by the researcher (appendix 6). The use of manual coding facilitated the emergence of outcomes considered significant by interviewees and recognised as relevant by the researcher. The analytical framework utilised as a structure within the data collection provided a foundation to structure the coding into categories (appendix 7). These reflected the service redesign measures implemented and provided an analytical framework for the comparison and convergence of the qualitative and quantitative data. Sub categories were identified and labelled highlighting emerging themes through abstracting key phrases from the transcripts. Every effort was made to avoid ‘force fitting’ codes to data, but it is inevitable that the researcher was influenced by existing knowledge of outcomes and issues arising from the service redesign.

Coding in this research was guided by Creswell and Plano Clark (2007) and assisted the researcher in the identification of patterns in the data. The findings highlighted that the empirical level perceptions of occupational therapists about the purpose, nature and outcome of their respective service was not congruent with the

events of service delivery at the actual level. Furthermore, the data analysis presented the therapists' account of the morphogenetic and morphostatic influences being largely due to structural causal mechanisms. Coding highlighted service sector specific associations concerning places, events, and circumstances.

2.8. Stage 3: Abduction/Theoretical Redescription

The third stage involves abductive inference, a means of interpreting and redescrbing different aspects of the phenomenon from hypothetical conceptual frameworks and theories about structure and relations. The original ideas of the objects of study are developed when placed in new contexts of ideas. Here several different theoretical interpretations and explanations can be presented, compared and possibly integrated with one another (Danermark 2002).

The concurrent triangulation design used in this research is one of the most commonly used mixed method designs (Tashakkori and Teddlie 2003). Triangulation within critical realism is firmly grounded in abductive reasoning (Modell 2009). Abductive reasoning is not logically rigorous like deduction, providing a complementary foundation for analysing the mixed methodology data to stimulate the research process during the emergent phase. Abduction involves analysing data that fall outside of an initial theoretical frame or premise (Habermas 1978, Collins 1985, Meyers and Lunney 2013). The phenomenon of minimising transitions of care was, as a consequence, redefined to the structural conditions for affective agency to deliver on the service redesign measures of patient continuity of care at an informational, management and relational level. During this emergent phase a comparative approach (triangulation) between qualitative (intensive) and quantitative (extensive) study aims were used utilising the continuity of care concept as an evaluation framework for analysis. Following deductive analysis of the mapping, tracking and semi structured interview methodologies, abstraction was used to discern relations and connections within the data that could not be reduced to the empirical experience described by participants (Danermark et al 2002).

In seeking to explain the events at the actual level, potential causal mechanisms that collectively produced the events under enquiry were isolated through drawing on the narrative accounts from the occupational therapists and pre-existing

knowledge taken from a variety of different cognitive fields. Literature from management and behavioural sciences was reviewed to augment the critical realism stance of this research. Notably the work of Argyris and Schon (1978) in respect to action theories and reflective practice and the street level bureaucrat work of Lipsky (2010) also informed the researcher's conceptual thinking. Accordingly, hypothetical conceptual frameworks and theories about the structural, cultural and agential inhibitors and facilitators to minimising the incidence of transitions of care were developed.

The macro, meso and micro level aspects of the phenomenon were delineated and deliberated, providing a multifaceted and stratified theoretical framework that conceptualised the potential generative mechanisms. The nature of abstractions are that they are synchronous – simultaneous. They take a “snap shot” in time by capturing events, their constituent structures, powers and mechanisms at a point in time. However, to understand the dynamic dimension about processes and change the abstract and the structural analyses must be supplemented by an analysis of the causal conditions (Danermark et al 2002).

2.9. Stage 4: Retroduction

Retroduction is the abstract process of causal analysis which determines the causal conditions or causal relations underlying events. It is closely affiliated with abduction and seeks to explain how the events came about. To ask what has caused something is ‘to ask what “makes it happen”, what “produces”, “generates”, “creates” or “determines” it, or, more weakly, what “enables” or “leads to” it’ (Sayer 1992: 104). From a realist perspective it is not a matter of a relation between two events, separated and demarcated from each other. It is a matter of what causal powers or liabilities there are in a certain object or relation. In more general terms it is a matter of how objects work, or a matter of their mechanisms (Danermark et al 2002).

The constitutive structures, powers and relations of the isolated inhibitors and facilitators of the service redesign objective (minimising transitions of care) identified in the abstraction phase were subject to retroduction. During this process, the objects i.e. inhibitors and facilitators were examined by posing the key questions as proposed by Danermark et al (2002) i.e. How is X possible? What properties must exist for X to be what X is? What causal mechanisms are related to X? The

objective was to extrapolate the powers inherent within the objects (by virtue of their structures) and determine the mechanism arising from these structures in relation to the object i.e. what triggered the mechanism to generate the event. This process of counterfactual (and transfactual) thinking included due consideration to the external and contingent nature of mechanisms being triggered and the conditions and circumstances required for them to operate i.e. what triggers the mechanism to generate the event in what circumstance. Hedstrom and Swedberg's (1998) classification of mechanisms into situational mechanisms, action-formation mechanism and transformational mechanisms served to structure the mechanism based theorising endeavour within this research; whilst the theoretical propositions informed by Archer's (1995) situational logic framework were subsequently developed to express the relationship between variables.

2.10. Stage 5: Comparison between Different Theories and Abstractions

Danermark et al (2002) identifies stage 5 as a phase in explanatory research and theory construction where comparison and assessment of the identified theories and abstractions is undertaken. The purpose here is not to test or confirm the theoretical propositions but to use further abductive reasoning to elaborate on the relative explanatory power of the mechanisms and structures. One theory or proposition is then identified as having the best explanation for the event if it is judged as more explanatorily coherent than its rivals i.e. it can predict and otherwise account for all the facts that rival theories do, but also explains the causes of other facts which the other identified rival theories do not. Determining the explanatory breadth of competing theories involved identifying the competing propositional statements within domains reflecting the service redesign measures. The relevant evidence that supported the explanatory propositional statements sourced from the quantitative and qualitative data findings outlined in chapters 4 and 5 were aligned to the statements. In line with Thagard's (1978) notion of simplicity and analogy, preference was awarded to theories that had fewer ad hoc assumptions and analogical connection to existing theoretical and scientific theories. The competing propositional statements affiliated with the most substantiated evidence statements were confirmed as the theories to have more explanatory coherence.

2.11. Stage 6: Concretization and Contextualisation

Concretisation involves examining how different structures and mechanisms manifest themselves in concrete situations. The importance of studying the manner in which mechanisms interact with other mechanisms at different levels, under specific conditions are stressed. The aim was to contribute to explanations of concrete events and processes by interpreting the generative causal powers of mechanisms. Within this research theoretical propositions deemed as having more explanatory coherence from the adjudication process undertaken in stage 5 placed the studied phenomenon in a context. This provided the framework to illustrate how the different structures and mechanisms manifest themselves in concrete situations. It also described the context that created the conditions for triggering the mechanism in question and facilitated the study of competing and complementary mechanisms in operation at different levels. This form of explanation establishes why regularities are operating in a particular context and illustrates the bearing of countervailing influences on these active mechanisms. The contextualisation and interfaces of the identified structures and mechanisms in context are discussed more fully in chapter 6.

2.12. Ethical Considerations

Traditionally, ethics requires consideration of issues such as not doing harm, not breaching confidentiality, not distorting data, informed consent, honesty and the right to withdraw (Denzin and Lincoln 2005). Critical research is required to account to the aforementioned ethical parameters of traditional research, but also needs to consider particular ethical issues relating to the explanatory critiquing nature of the research approach. The critical realist paradigm goes beyond simply being evaluative in deriving normative implications by studying social beliefs. Crucially, through abduction and retroduction, critical realism data analysis judges the truth or falsity of the social beliefs (Mingers, 2008). Most traditional ethical theories generally take a subjectivist position, assuming levels of rationality in the decision making of the individual. In contrast, critical realism in making a distinction between the transitive and the intransitive realms of reality recognises that people hold many unacknowledged and potentially false beliefs (Mingers 2008, Bhaskar 1975).

The methodology within this evaluative research was orientated towards understanding the generative mechanism activated as a result of the introduction of service redesign measures to minimise the incidence of transition of care for patients. The cultural and psychological processes of human activity as well as the observable behaviours were the focus of this research. The researcher played a central role in making methodological choices as to the mode of data collection and in drawing insight from the information generated through data interpretation, and ultimately in the theorising as to plausible explanations through a process of adjudication. To create an ethical and emancipatory pulse to this critical realism research, issues of power and collaboration within relationships, building trust, setting context for inquiry, reciprocity and sharing of findings were key elements that had to be considered in the research design (Lacey 2007).

This evaluative research required the active participation and collaboration with the research participants in a range of data collection methodologies commensurate with the triangulated research design adopted i.e. mapping, tracking and semi-structured interviews. Each participant engaged in the data collection methods was informed of the context of their agreement to participate as part of the discrete methodologies as they were initiated and implemented. Specific permissions associated with auditory taping (mapping and semi-structured interviews) and direct observation of practice (time and motion) were also accommodated within the specific data collection methodology consent arrangements. The informed status of research participants was enhanced by virtue that this research was implemented as part fulfilment of a Knowledge Transfer Partnership Project. This introduced a systematic and complementary communication strategy that provided an inter-organisational structure to communicate the results of this PhD's mapping and tracking research findings to stakeholders at all levels within the organisation, including executive management levels.²¹ The provocative research data illustrating the dissonance between the occupational therapists' empirical level perception of services and the observed events at the actual level was presented to staff within a structured shared learning environment. The endeavour sought to confirm the falsity of beliefs held through cognitively critiquing the evidence from the data sets and

²¹ Stakeholder feedback engaged participating research occupational therapy participants, their managers and senior managers to Executive Director (Social Work) and Chief Executive (NHS Lanarkshire) positions

engaging the research participants in informed decision making within the service redesign programme of change.²² The critical realist model of social enquiry aims to enable participants to see themselves under a new description which they have helped to create (Bhaskar 1989). The subsequent semi-structured interviews involved informed participants who had been actively engaged in the preceding data collection methodologies and associated communication and decision making events. The semi structured interview sought to inform the development of plausible explanations of the service redesign outcomes by eliciting the experiential views of practitioners and managers who had agreed to implement the conceptual service redesign measures developed in line with the collaboratively endorsed service priorities from the option appraisal events.

The corporate nature of the communication strategy that engaged senior management buy-in is advocated within change management literature (Senge 2006, Seddon 2008). However, the unintended coercive powers and influence of the explicit intent of senior managers, albeit by proxy, to support the service redesign may have placed an undue pressure on the research participants to comply (or espouse a commitment) with the terms of the service redesign development and implementation. The practitioners' right to choose to withdraw at any time from any of the research data collection and implementation methodologies was explained and emphasised as a compensatory measure. The challenging nature of the practice and service transformation arising from the service redesign measures generated a degree of discomfort for the research participants engaged in its implementation as they were required to become familiar with and adopt new practice and management arrangements. This was further accentuated as their pre-existing personal epistemological perspective of their practice was continually challenged in the implementation of the service redesign measures. The researcher, in acknowledgment of the tensions this evoked, was instrumental in the establishment of collaborative management forums designed to respond to and address the specific practitioner anxieties and service challenges under the auspices of the Knowledge Transfer Partnership Board membership. Within this context, bespoke supportive measures were implemented through substantive line management structures. Efforts were taken to ensure the preserved anonymity of

²² Service redesign measure option appraisal

these participants and, where practicable, the description of an individual's practice experience within the presentation of the data was kept deliberately nebulous in order to fulfil the ethical commitment to confidentiality. These supportive management measures also contributed to the ethical and moral obligation of doing no harm by taking responsibility and protecting the practitioners who participated within this research (Arksey and Knight 1999).

2.13. Insider – Outsider Researcher, Reflexivity and Power

The debate with regard to the relative merits and limitations of assuming an insider or outsider perspective in evaluation research is longstanding and centres on the fundamental question about whether the subjective knowledge and perspectives of stakeholders is key to the evaluation, or whether objective methods is paramount in the evaluation of a programme. The former engages with stakeholders in the development of a shared understanding about programme improvements, whilst the latter relies on objective methods to make determinations about the efficacy of the programme, limiting stakeholder engagement to that of data sources within the research design (Collins 1990). In describing the critical realist approach, Pawson and Tilley (2004) emphasise that research participants are regarded as central sources for eliciting programme theory and providing data on how a programme works. However, the authors stress that it is not assumed that the participating stakeholders are all-knowing, nor that they will necessarily agree on how, for whom and in what circumstances a programme will work (Pawson and Tilley 2004). This perspective is qualified by an acknowledgement that participants generally have experience and expertise in particular phases and process within an intervention. Ultimately, evaluation from a critical realist paradigm is characterised as requiring data from what Pawson and Tilley (2004, pp.12) describe as a “bricolage” of data sources. These are derived from stakeholders from an individual and collective basis, but also incorporates more objective data sourced from observations in respect of, for example, processes and outcomes within institutions and infrastructures.

The mixed methodological design of this research warranted a plurality in the ways of dealing with the inherent subjectivity of the researcher. In collating the data specific to the actual level events, attempts were made to diminish the effect of the

researcher's subjective position on the outcomes of the study. In seeking objectivity, triangulation and measures to promote inter-rater reliability were adopted as previously described within this chapter. The data collection at the empirical level similarly acknowledged the researcher's subjectivity and bias. The issue of how much the researcher's own values influenced the representation of the external reality were considered by engaging in reflexivity.

As a qualified occupational therapist with previous practice and management experience within occupational therapy services in both NHS and Local Authority public bodies, my positionality within this research was that of an insider researcher. My insider perspectives in this research are coloured by my exposure to a range of related vocational experiences within these settings over a period of nearly three decades. However, my current employment as a senior manager within South Lanarkshire Council has distanced my direct involvement with the management of Local Authority occupational therapy services and the levels of responsibility are commensurate with the position, which has responsibility for the occupational therapy service as part of the extended social work resource. My direct management of NHS occupational therapy services concluded in 1992²³, though my influence in joint strategic ventures, including the commissioning of the Knowledge Transfer Partnership Project on behalf of the Local Authority, in which this research is embedded, has remained a consistent responsibility within my role. From this perspective, my position is that of an outsider relative to that group with an organisational position that offers a degree of power and influence not routinely held by researchers.

Hamnett et al (1984) profess the advantages of adopting both insider and outsider perspectives on research endeavours wherever possible. The belief is that insider research can provide subjective dimensions that enrich the depth and understanding of research findings, which may escape the consideration of outsider perspective. However, the value of the outsider position is the ability to bring comparably detached perceptions to the area under study and reduce the effects of the proverbial "can't see the wood for the trees". The recommendation is for the insider-outsider researcher to consciously develop structures to think critically about their positions, processes and relationships and the quality and richness of their data and analysis through reflexivity (Hamdan 2009). Reflexivity is critical in determining the

²³ Within Grampian Health Board and not the research site of NHS Lanarkshire

power relations and the exercise of power in the research process (Ramazanoglu and Holland 2002). Reflexivity is categorised by the scholars into four levels for reflection in the research process: (a) the identification of power, power relationships and its effects; (b) theory of power relations (hidden and explicit); (c) ethical decisions in the research process, and the politics and interests of those that make those decisions; and (d) accountability for knowledge production.

Reflecting on my positionality within the study as the experienced qualified occupational therapist with inside knowledge of systems and practice; as the senior manager with authority and influence; and as the researcher and custodian of expertise and information concerning the performance of services and the meaning of the research subjects' experiences, has assisted in understanding the way others construct my identity. This in turn contextualised my engagement in the process of reflexivity and ultimately in the research process in a more meaningful way. Although it is not possible to eliminate power disparities between the researcher and the researched (Hamdan 2009), it was imperative that I attempt to address the balance of priorities by being transparent and explicit in my research objectives; challenging my values and assumptions in the collation and analysis of the data and generating systematic opportunities conducive to obtaining and effectively recording the genuine perspectives of the researched on, the research process, and the results e.g. utilising technology to elicit anonymised responses to preset questions. Accountability to a governing management structure in the form of the Knowledge Transfer Partnership Board with representation from senior managers from the respective partners also served to temper biases arising from my subjectivity, as decisions required to be justified and were subject to independent scrutiny and challenge from a range of inter-organisational stakeholders' perspectives.

In practice, the insider perspective supported me to be mindful of my subjectivity and structured my self-reflection to elucidate my perspective on the research subject, whilst simultaneously becoming increasingly aware of the multiple realities perceived by the participants involved within the evaluation research, whether they were stakeholder partners, researchers or practitioners. From an outsider "objective" empirical position, and through the application of measures to make sense of the outcomes (coherence theory of justification), my perspective evolved to a more

reasoned and removed interpretation of reality. This in turn offered new perspectives on the analysis and interpretation of the data.

2.14. Respect for Intellectual Property

This evaluation research was embedded within a Knowledge Transfer Partnership project which provided a comprehensive source of data and access to an extended range of resources, including academic advice and contributions²⁴, which would not otherwise have been afforded this PhD. The breadth of the data sources and perspectives within this context created an invaluable resource from which this PhD (and the researcher) could develop. The PhD researcher's organisational position as the South Lanarkshire Council representative on the Knowledge Transfer Partnership Board, both as a commissioner of the project and a practice supervisor, provided the researcher with a relatively unique position from which to inform and influence the focus and direction of the Knowledge Transfer Project. In line with the principles for collaborative and contract research, the Knowledge Transfer Partnership and funding partners completed an Intellectual Property agreement²⁵ as part of the terms of the collaborative research contract before the project commenced. The subsequent development of the project evolved and the specificity of the methodologies adopted within the collaborative venture evolved.

In the interests of transparency and proper acknowledgement and credit in respect to these contributions, it is necessary to clarify the status of the methodological approaches developed and utilised within this PhD vis a vis the complementary methodological approaches attributable to the Knowledge Transfer Partnership. The mapping, time and motion and semi structure interview methodologies were developed²⁶ and executed directly, or indirectly, under the instruction of the

²⁴ Queen Margaret University and Stirling University academic Knowledge Transfer Partnership Board members and Knowledge Transfer Partnership academic lead.

²⁵ PhD student as South Lanarkshire Council commissioning representative and Knowledge Transfer Partnership Board member engaged in review and sign off of Intellectual Property agreement

²⁶ Methodologies developed as part fulfilment of the PhD evaluation research; although advice and guidance on the development of these approaches were informed by the contribution of the academic Knowledge Transfer Partnership members, including the Knowledge Transfer Partnership associate

Chapter 2. Theoretical Position and Research Methodology

researcher²⁷. The mapping and time and motion methodologies developed within the auspices of the PhD, were inextricably enmeshed within the Knowledge Transfer Project in that this data and findings served to direct the service redesign priorities of the Knowledge Research Partnership Project's focus and framed the associated research participants and extended stakeholder consultation events. This was inclusive of the option appraisal and option rating exercises undertaken, but also included an extended range of collaborative events to both inform and engage research participants and stakeholders at a local and national level²⁸. The retrospective case record analysis was developed under the auspices of the Knowledge Transfer Project and the data collection was undertaken by the Knowledge Transfer Partnership Associate, although the researcher contributed to the methodological design. The analysis of the pre and post retrospective case record data presented within this PhD was undertaken by the PhD researcher independently of the Knowledge Transfer Partnership. Permission was sought and granted to analyse this data source as part fulfilment of the PhD evaluation.

This research has drawn on an established explanatory research model illustrating how and why the intervention has functioned in the way that it has. Although the findings are not transferable to any other context, the principles of how the model was used may be useful as a guide to others seeking to develop explanatory representations of intervention schemes operating in other contexts. Researcher judgement is a crucial element in deciding what can be taken from this research and applied in another context.

2.15. Ethical and Research Development Approval

Ethical review by the NHS Research Ethics Committee (REC) was not required for this research under the terms of the governance arrangements for the Research Ethics Committees in the U.K. (Appendix 8). South Lanarkshire Council did not operate a formal ethics committee at the time the research was being undertaken,

²⁷ Research methodology directed by the researcher but executed by research assistants specifically employed to undertake the task (through the Knowledge Transfer Partnership funding)

²⁸ National events to disseminate findings organised and sponsored by the Scottish Government Joint Improvement Team

but the research proposal was submitted for formal approval and authorisation. This was granted. As a result, formal ethical procedures were not required to be completed for this research. However, in line with the recommendations within the Ethic and Research Governance Guidelines proposed by the Medical Research Council (Medical Research Council 2006), considerations were observed to ensure that good practice was maintained throughout the research. Verbal consent was obtained from the service stakeholders prior to the study.

2.16. Critical Realist Evaluation Limitations

Critical realism research in health and social care is a relatively new approach and consequently there are limited publications demonstrating its application and utility within this field (Dobson 2012). The six step explanatory model of critical theory (Danermark et al 2002) provides a practical framework to inform the theoretical application of critical realist research, but does not provide a methodological blueprint in respect to the research design and methodologies. The authors emphasise that the model should be seen as a guideline and not as a template, advocating that the research methodology should be structured in accordance with the contingencies of the phenomenon under study (Danermark 2002). Whilst this affords the researcher scope to develop methodological approaches most befitting the area of study, the challenge to identify what was methodologically legitimate was, as a relatively inexperienced researcher, at times disconcerting. This was accentuated by the fact that this research was embedded within a Knowledge Transfer Partnership Project with more conventional paradigmatic approaches to evaluation. Although this learning context reaped significant benefits in terms of data sources and resources, the organisational and academic milieu presented competing ontological perspectives on evaluation. Ultimately, the methodological design of this PhD's evaluation research relied on the critical realism ontology of causal structures which guided the researcher to the appropriate scientific procedures adopted and provided plausible alternative interpretations and explanations for the observed service redesign outcomes.

The nature of the approach adopted in this research meant that all conclusions and findings are necessarily context specific and this contextual specificity could be considered a limitation by researchers who value generalisability. However,

progress is made when conclusions and findings developed in one context are applied in other contexts and shown to add value.

Adopting a critical realism approach to evaluation research is enormously intellectually challenging. It requires a theoretical understanding and sustained thinking to determine the scope of the phenomenon to be investigated and systematic and innovative abilities to design the research and undertake the transfactual and counterfactual thinking required for data analysis. The inherent practical limitations of developing theoretical propositions to test are acknowledged within the literature (Pawson and Tilley 1997), as not every explanation will be accounted for, as not every eventuality will be anticipated. The extent to which this is exhausted is dependent on the knowledge, expertise and creativity of the researcher(s) involved. Each theoretical proposition requires to be validated if generative causal relationships are to be inferred. As a result data sets are at risk of being incomplete, skewed or biased. On the philosophical presumption that there may be multiple mechanisms in operation concurrently, the process of revealing and testing the underlying generative mechanistic configurations in context is fundamental to better understand what is occurring, or has occurred (Pawson and Tilley 1997).

A particular challenge within this research was in being able to clearly define mechanisms, and delineate between structural and cultural influences in context. Theoretically, a mechanism provides an explanation as to the constellation and interplay of variables within a programme that result in the observed or hidden outcomes at a micro, meso or macro level. The application of the principles of abduction which primarily comprise data interpretation by the researcher was constrained by the fallibility of the researcher. Equally, attempts to develop and link plausible explanation and causality through retroduction were circumscribed by the researcher's epistemological standpoint that may have inadvertently resulted in correlations and associations being inappropriately conflated. Errors and limitations in the research methodology including data sources, collection and analysis would compound the capacity for and authenticity of effective counterfactual argumentation. Methodological approaches such as action research to actively engage occupational therapists and managers in systematically identifying potential

formative new mechanisms would have produced a more comprehensive logic of discovery in the process of abduction.

Equally, the researcher's engagement at the inception of this longitudinal practice and system service redesign accorded the researcher with a favourable research context from which to develop systematic approaches to record the occupational therapists' espoused experiences of the process up to, during, and post the implementation of the service redesign measures. However, the researcher was remiss in not incorporating the use of ethnographic methodologies to initiate the retroductive journey at the service redesign consultation and planning phases. Linking rich individual accounts to various stratified contextual layers during the emerging process would have enhanced insights into the phenomenon under study and potentially have uncovered additional structures and mechanisms in the development of the conceptual framework for analysis.

A further limitation of this research design relates specifically to the semi-structured interview format. The interviews were undertaken following the full implementation of the service redesign measures and as part fulfilment of the post service redesign evaluation methodology. The semi-structured interview format was used as a tool to explore the participating occupational therapists' agency within the context of the service redesign outcomes. Knowing the empirical and actual events from a collective perspective shaped the content and format of the semi-structured interviews encouraging occupational therapists to recount their experiences and share their perspectives in general terms. However, the themes that emerged from the findings from other data sources at the actual level could have been specified and attributed to individual occupational therapy practitioners. The semi structured interview format could have then raised specific queries about inconsistencies in respect to individual practice whilst providing an opportunity to challenge the adequacy of accounts provided where appropriate. The data representation operated at the level of the occupational therapist's espoused general experience, rather than at any deeper level. Despite these limitations in the research methodological design, conducting the research was educational for the researcher, who has developed through the experience not only in terms of a personal epistemological shift, but also in terms of being better equipped in methodological

Chapter 2. Theoretical Position and Research Methodology

techniques such as abduction and retroduction. In line with the ontological stance of critical realism, the limitations of the data are presented as tentative and fallible on the understanding that middle range theory cannot provide an exhaustive explanation for change Pawson and Tilley (1997). The intention was to provide illuminating data and options for improvement rather than a perfect understanding of the intervention and its outcomes.

Chapter 3: Partnership Working – Legislative Drivers and Policy Influences

3.1. Introduction

The aim of this thesis is to explore and understand the outcomes of an occupational therapy service practice and system service redesign aimed to minimise the incidence of patient transitions of care through measures to promote continuity of patient care in line with the Government's health and social care partnership working strategy. The diversity of the literature subject matter within this chapter acknowledges the complexities of evaluating a multifaceted and stratified socio-historic reality. The agential volition of the occupational therapists and the embeddedness of their actions within a wider social context is of specific interest within this thesis. As such, the political, organisational and social context, as well as related theoretical concepts need consideration to inform the analysis of the service redesign within the policy context. The literature review within this thesis was initially informed by an exploratory structured search of the literature included in peer reviewed articles; purchased literature and literature accessible via electronic databases and libraries; published reports and evaluations; current research activity and unpublished dissertations. The key words initially used were health and social care partnership working, health and social care integration, occupational therapy and care of the elderly, transitions of care, public service performance metrics and social science. As the research evolved and themes emerged, further literature was sourced in accordance with the nature of inquiry. This included literature on research methodology, with a specific emphasis on critical realism and mechanism based theorising. Literature on continuity of care and organisational learning was also sourced, as were theories that informed the development and analysis of this research. This included Vangen and Huxham's (2005) Theory of Collaborative Advantage, Bevan and Hood's (2006) Theory of Governance by Targets, Lipsky's (2010) Theory of Street Level Bureaucracy and Argyris and Schon (1978) Theories in Action. The resulting breadth of literature presented within this thesis is a synthesis of the diverse literature review.

This chapter commences by providing an overview of the unprecedented demographic and fiscal challenges facing public services with a specific emphasis on health and social care within Scotland. This socio-economic context is central to the government's philosophical and strategic policy action enacted through key

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

legislative, policy and structural changes aimed to promote partnership working (section 3.2 and 3.3). Section 3.4 outlines the governance infrastructures mandated by central government in efforts to drive performance in line with the public service modernisation programme and illustrates the counter-productive behaviours by the workforce in response to predefined measures that effectively distort and manipulate the system and undermine the strategic objective of partnership working to deliver public service efficiencies. The manifestation of these behaviours is reflected in section 3.5 which outlines the empirical evidence that suggests that inter-organisational partnership arrangements are difficult to manage and often fail to meet expectations. My choice to include considerations from the policy landscape reflects the political context of health and social work organisations arising from the administration and governance structures at central and local government respectively. The political and organisational situations are important elements to acknowledge given the influence they have in creating the context for system and practice change as is being evaluated within this thesis.

Section 3.6 further explores the complexity of partnership working and introduces the theory of collaborative advantage (Vangen and Huxham, 2005) as a construct to consider a range of collaborative tensions that energise or constrain partnership working in terms of structural and agentic variables within a complex stratified organisational context. This literature serves to extend the structural /agential considerations at play within this thesis and reemphasises the significance of antecedent contexts in the exploration of the dynamic interplay of competing generative mechanisms arising from the introduction of the service redesign measures.

The final area of policy identified as pivotal to the topic of this thesis is the policy drive to achieve person centred services. This will be presented and discussed in section 3.7 under the auspices of patient continuity of care; a concept closely affiliated and embedded within the partnership/integration policy framework and one that serves to structure and enlighten this thesis' perspective on investigation and analysis. This thesis' exploration as to the impact of implementing a service redesign, fashioned on a central government policy, on patient continuity of care is reflected at an informational, management and relational level.

Sections 3.8 to 3.12 turns to framing the partnership challenge from a sociological perspective in attempts to answer theoretical questions about social order, action and change. Abstract theoretical frameworks are explored to conceptualise the social phenomenon under study and support the research deliberations. Section 3.9. presents the central sociological theoretical dichotomies of subjectivity and objectivity, structure and agency and synchrony and diachrony. It also consider the implications of these opposing perspectives within the contemporary theories of structuration and morphogenesis reflecting the critical realist perspective of this thesis. The theoretical conceptualisation of the structural and agential variables at play in implementing the macro-policy aspirations of partnership working at both the meso-service level and the micro-practitioner level provides this research with a framework to conceptualise the micro versus macro conundrum. Section 3.10, considers the idea that causation can be explicated through mechanism based theorising and the at the micro, meso and macro levels of organisational analysis are explored under the auspices of Hedstrom and Swedberg's (1998) categorisation of situational, action formation and transformational mechanisms.

Sections 3.11. and 3.12 present theories selected to provide further conceptualisation of the relationship between practitioner's (agents) and their practice at the micro level, within the context of the organisational structures at the meso level and the macro influences at the policy level. Section 3.11. introduces Lipsky's (2010) theory of 'Street Level Bureaucracy' highlighting the agency of the practitioner within public services and the discretionary power held to influence and shape the implementation of public service policy at the meso-service and organisational levels. Section 3.12 considers theories of organisational learning, reflecting that the capacity for organisational transformation, as was the aspiration of the occupational therapy service redesign, is through the capacity to learn. The Theories of Action proposed by Argyris and Schon (1978) offered a theoretical structure from which the learning at an agential and organisational level could be explored within this thesis.

Finally, sections 3.13 and 3.14 considers the inherent capacity and limitations of the uniquely positioned occupational therapy profession to transcend the health and

social care organisational divide to achieve the efficacy aspirations sought by the policy context. Firstly, occupational therapy is defined and a brief socio-historic context as to the profession's employment within both health and social care authorities will be described. The conceptual values and principles to which occupational therapy affirms its allegiance will also be presented. The combination of the socio-historic experience of the profession and the conceptual foundations of the knowledge base converge to create a sense of identity informing the values, attitudes, and practices of a profession. The practice implication of adopted these standardised assessment and outcome measurement tools are explored within the sociological context of the service redesign. Exploring the identity of occupational therapy in this thesis is important to inform the exploration of the agent, structure interface. Section 3.14. concludes this chapter by contextualising the occupational therapy profession's locus within the central government modernisation programme, with a specific emphasis on the Joint Future (2000) agenda. The Joint Future agenda identifies the profession of occupational therapy as central to this strategic policy development and is outlined in the context of serving to inform the structure, development and implementation of the service redesign focus within this thesis.

3.2. Partnership Working: Demography and Fiscal Challenge Context

People in Scotland are living longer and with multiple long-term conditions and increasingly complex needs. Currently an estimated two million people in Scotland have at least one long-term condition, and one in four adults has some form of long-term illness or disability. (Audit Scotland, 2016). The demographic projections from 2014 to 2039 suggest that demand on health and social care will continue to increase as a result of Scotland's ageing profile. The biggest changes are predicted in the 75 and over population. The number of people aged 75 and over is anticipated to increase by around 85% in the next 25 years; whilst those 90 and over are predicted to triple by 2039 (National Records Office, 2016). The significance of this demographic statistic lies in the realisation that by the age of 75, almost two-thirds of people will have developed a long-term condition. The ageing population and increasing numbers of people with long-term conditions and complex needs have already placed significant pressure on health and social care services. The Scottish Government estimates that the need for these services will rise by between 18 and 29 per cent between 2010 and 2030.

In the face of these increasing demands, the current model of health and care services is unsustainable as the projected level of annual financial investment required is untenable (Audit Scotland, 2016). Public bodies have been required to achieve annual targets of 2% savings since 2004, totalling an estimated £4 billion in efficiency savings to the end of the financial period 2009/10. This trend continued as the Scottish Government committed to reducing the public spend via the Efficient Government Initiative by a further 11% from £29.2 billion in 2010/11 to £25.9 billion in 2014/15 (Audit Scotland 2011). The annual efficiency saving exercise persists in 2016/17 as the savings levied against Health and Social Care services is a further 3.6% (Audit Scotland, 2016). The Scottish Government anticipates that spending levels are not anticipated to return to 2010/11 echelons until 2024/25 and this is largely predicated on the success of the UK government policy to reduce the national debt levels (Audit Scotland 2011). The scale of the budget cuts over the past 12 years brings immediate and longer term challenges for the Scottish public sector to reduce expenditure and ensure long term sustainability of future health and social care services, whilst maintaining or improving the quality of services delivered to the public. The Scottish Government's political priority is to generate inventive strategic solutions at a macro level to facilitate greater productivity within health and social services as a method to contain cost and improve quality (Wilkinson 1997).

There is a long established history of Government legislation, related policy guidance and structural change aiming to realise financial economies within health and social care. The approach across the UK has been to promote partnership working and integration between health and social care as a means to affect major policy and practice level changes within public services in order to meet the nation's fiscal challenges. The absence of specificity in the definition of integration affirms the significant challenges in the level of understanding, successful application and evaluation of this approach (Leutz 1999, Kodner and Spreeuwenberg 2002). The numerous concepts, logics and methods within the definitional spectrum of the term integration is aptly characterised by Ling (2000, pp. 82) as "methodological anarchy and definitional chaos". Proliferate definitions abound, categorising integration in term of levels, breadth, depth and degree creating a definitional quagmire (Curry and Ham 2010).

In simplistic terms and for the purpose of orientating this study, an important distinction is drawn between integrated organisations and integrated or partnership working. The former refers to structural integration between organisations and the latter, of particular interest within the scope of this study, being interpreted as health and social care professionals working together to deliver coordinated care to the patient within and across discrete organisational structures (Petch 2012). Curry and Ham (2012) build on this distinction by delineating between the different levels of integration as macro, meso and micro levels of integration. The macro definition corresponds to integration at an organisational structural level where organisational structures merge and assume a unified corporate body with a legal identity. The meso level relates to integrated service level arrangements to defined patient care groups through the establishment of inter-organisational measures such as disease management programmes, redesigned care pathways and managed clinical networks; the emphasis is on partnership working at a service level, but the organisational identities remain separate. Similarly, the micro level of integration focuses on partnership or integrated working through practice level arrangements that seek to deliver integrated care to individual patients through care planning approaches.

In recognition that much of the debate and analysis about integration is from an intra-organisational perspective, primarily within health services, a further distinction is drawn between horizontal and vertical integration. Horizontal integration refers to services or organisations coming together to deliver care and support at the same level (e.g. mergers of acute hospitals), whilst vertical integration occurs when services merge to deliver care and support at different levels (e.g. secondary and primary care and/or community care). Again, for the purpose of clarity, this study's emphasis is on the vertical dimension in respect to occupational therapy services across acute, primary care and local authority organisations. The emphasis, irrespective of definitional status is to achieve connectivity, alignment and collaboration within and between health and social care services as a means to create organisational efficiencies and improve the patient experience of public services. (Kodner and Spreeuwenberg 2002).

3.3. Partnership Working: Governing Political Philosophy and Policy Action

The NHS and Community Care Act 1990 formalised the contemporary theme of integrated/partnership working between health and social care. This legislation, coupled with the successive White Papers “New NHS: Modern, Dependable”, “Modernising Social Services: Promoting Independence, Promoting Protection, Raising Standards” and “Designed to Care” in 1997, culminated in the strategic document “Modernising Community Care: An Action Plan”, which was published in 1998. This publication enshrined the new Labour Government’s promise of an innovative “Third Way” of working. The Third Way encapsulated an ambitious political philosophy advocating a synthesis of right-wing economic strategies which supported free market principles, whilst upholding left-wing social policy values (Driver and Martell 2000, Glendinning and Means 2004).

The defining principles of the Third Way was a belief in harnessing the neo-liberal regime of freely mobile resources whilst founding the origins of the “Big Society” in extolling the virtues the community, citizenship, equality and an emphasis on responsibility and accountability (Goodship et al, 2004). Although vilified within some quarters as being little more than a political game plan to secure electoral success with no real theoretical basis (BBC 1999), the Third Way’s ideological concepts have undeniably had a particular significance in British politics. The approach’s influence has withstood changes in political administrations and the Third Way’s ideologies have served to shape welfare reforms for almost two decades (Jordan 2001).

The uniting objective at both central and local government level was to “join up” service provision providing a seamless service to the public by breaking down traditional organisational boundaries. The emphasis was to realise system efficiencies by developing cooperation between organisational entities which were perceived as being bureaucratic, fragmented, service driven and inefficient. The drive to curtail public expenditure was further enhanced by the Third Way’s approach to social democracy. The welfare state was considered to be unsustainable both in terms of cost and fundamental concept as public dependencies were created and moral hazards were introduced through perverse

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences incentives (Giddens 1998). The mandate was to reduce the avoidable economic burden on society by capitalising on the public's inherent capacity to be independent from state support on an individual and collective basis. The political opportunity to introduce new forms of moral regulation which valued the contributions of people and services in the care of patients out with public service employment fueled the Government's strategy to promote individual responsibility and collective community action (Williams 1999). Putting People First (Department of Health 2007) enmeshed the concepts of Personalisation as a central component to the government's modernisation strategy.

The Third Way's emphasis was on strategies to empower patients rather than cosset them within paternalistic service constructs. The patient was reconceptualised as an active participant within social relations of welfare rather than a passive recipient, with personal powers, knowledge and responsibilities that afforded them a degree of autonomy in exercising choice and control in respect to their care (Williams 1999). The objective was to foster an asset based culture which promoted individual independence, recovery and self-management. (Alliance 2013). Duties to empower patients to make decisions and be in control of their care and treatment were underpinned by key legislative directives embodied within the Community Care (Direct Payment) Act 1996, the Human Rights Act 1998 and the Equality Act 2010. Public services were charged to develop their approaches not only in partnership, but also in line with the aims and objectives of the personalisation agenda. This crucially demanded a shift in the professional and organisational paradigms of engagement with the patient from that of "fixer" to "facilitator". Empowered patients with self-assessment and self-management skills and responsibilities would become collaborative partners in the management of their health and social care; whilst the new found purchasing powers introduced by the Direct Payments legislation created the opportunity for patients to shape the social care market within the third sector through the commissioning choices they exercised in meeting their needs. (Ham et al 2012).

The Government's Third Way synthesis of right and left wing social policy values advocated a person centred approach which commanded a fundamental shift in practice within the planning, commissioning and delivery of services within health

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences and social care. Reactive, service led models of care, of variable quality, were to be replaced by a mainstream system focused on personally tailored services with an emphasis on prevention, early intervention and enablement (Bartlett 2009).

The Third Way's political stance on ethical socialism, reformism and gradualism predicated the presiding Government's disinclination to pursue measures to affect wholesale structural integration (BBC 1999). The tactic was to introduce a strategy that fundamentally valued existing health and social care institutions but ultimately sought to incrementally affect sustainable change within the public service system through developments that supported partnership working. The introduction of a number of legislative and policy initiatives staged over a period of a decade and a half systematically altered the legal and political context of inter-organisational engagement. The strategy centred on services delivered to older people as the biggest consumers of public services and was driven by performance, incentivised by improving the quality of services delivered to the patient (Humphries and Curry 2011). Legislative macro level measures created new powers to redress what was perceived as the persistent planning, financial and commissioning barriers to integrated/partnership working. The introduction of the Health Act (1999) created opportunities and obligations for the NHS and social care authorities to cooperate by revoking historic legal organisational management and planning boundaries.

Amidst this context for change, the Scottish Executive set up the Joint Future Group in 2000 to align existing policy directives with practice examples of innovative projects across Scotland in efforts to share learning and accelerate the response to the integration agenda (Stewart et al 2003). The Joint Future Group strategy is of particular relevance and specific interest within this research and will be contextualised and deliberated within the results of this thesis. Successive legislation, including the Community Care and Health (Scotland) Act 2002, the Local Government in Scotland Act (2003) and the NHS Reform (Scotland) Act (2004) all served to further advance and formalise the joint management and financial arrangements in respect to community care. This legal context for change was accompanied with a succession of centrally mandated macro level structural and system reforms and central governance infrastructures. Local Health Care Cooperatives (2000), Joint Partnership Groups (2003) Community Planning

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

Partnerships (2003), Community Health Partnerships (2004) and Community Health and Social Care Partnerships (2004) emerged in quick succession to deliver on centrally driven policy objectives. The aspiration was that these local partnership structures would be empowered to develop local strategies based on locally determined needs (Newman 2001). *Shifting the Balance of Care* (2009) served as the primary policy driver shaping the local partnership activity in respect to joint approaches to service development and delivery. The vision emphasised *shifting the locus and focus* of care. The presiding emphasis on expensive acute hospital based services, providing episodic care, was to be replaced with a focus on developing community based service capacity through the development of continuous, integrated care that delivered personalised bespoke support for patients and carers.

Despite the concerted and sustained efforts to create an overarching vision with central and local direction for implementation, the strategies to develop and embed integrated working arrangements between health and social care continued to be elusive and appeared to be impervious to change (Humphries and Curry 2011). The Government's frustration at the pace of change was palpable and the general sentiment at a local level was equally one of frustration and friction as the number, duplicity and incoherence of the centrally mandated local structures generated a cluttered landscape of health and social care structures and service drivers (Audit Scotland 2011).

The complexities of these partnership arrangements were accentuated by the fact that the Scottish Government (and its predecessor, the Scottish Executive) did not develop health and community care related legislation and policy jointly (Stewart et al 2003). This was counterintuitive to the spirit of the governing strategy intent on partnership working and integration. As a consequence, the implementation of the respective legislative duties and policy guidance by the health and social care organisations at a local level were beset with duplicate arrangements that lacked clarity of purpose and an inconsistency in accountability (Petch et al 2005). The statutory status of each partnership, led by either Health or the Council, varied and created discrepancies in the level of influence and authority to effect the developments required at a local level. In many areas, NHS Boards' local delivery plans, CHPs' development plans and Councils' social care service plans did not

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences explicitly set out a united vision, shared priorities and outcomes, an aligned resource framework or joint performance monitoring arrangements.(Audit Scotland 2011).

The pace and uncoordinated nature of the related policy reform within health and social care is noted by McMurray (2007) as having served to destroy existing inter-organisational communication channels, decision processes and relationships. In effect, the disjointedness of the strategic macro level drivers from the Scottish Government served to complicate and destabilise rather than consolidate and streamline the developments at a local level (Hudson and Henwood 2002). These incongruities resulted in a fundamental misalliance between the strategic macro drivers for inter-organisational change orchestrated by central government, and the reality of implementation at the meso and micro local government public service levels.

The UK Government extended its resolve in delivering on the Third Way's doctrine. The Reshaping Care for Older People policy (2011) document marked the new administration's perspective on partnership working/integration and personalisation. The document refined and built on pre-existing strategies, whilst introducing additional legislative and strategic policy drivers to advance the legislative and policy stratagem on integration from compulsory partnership to compulsory integration (Hudson and Henwood 2002). The introduction of the new Public Bodies (Joint Working) (Scotland) Act 2014, coupled with the simultaneous £300 million financial investment over a 4 year period, is reminiscent of action taken in the era which saw the introduction of Modernising Community Care as the guiding strategy for integrated working and the Community Care and Health (Scotland) Act 2002 as the supportive legislative framework.

The provisions within the Public Bodies (Joint Working) (Scotland) Act 2014 reflect removed the "voluntary" premise for integration and creates the legal requirement for health and social care organisations to become integrated in one of two ways (Cameron et al 2012). The first is as a body corporate through the establishment of a Joint Integration Board, and the second is under the auspices of a delegated authority structure whereby health and social care authorities determine which organisation will assume responsibility as lead agency for which statutory functions.

Both models are charged with developing joint local strategic plans for submission to, and approval by the Scottish Ministers who reserve the jurisdiction to make provisions as they see fit in the administration and monitoring of local partnership integration developments (SPICe 2013). The unusual extent of intervention powers accorded Ministers within statute, (enabling Ministers to remove functions from organisations where they are considered to be failing and enforce measures), is perhaps a manifestation of the Government's frustration that the policy rhetoric throughout the decades has repeatedly been misaligned with the practice reality (Petch 2012). The centrally prescribed and governed mandates within the Act are notable in marking a decisive shift within the Government's approach from that of an entrepreneurial governance mode of engagement to one that reasserts a more overt risk adverse bureaucratic style of governance (Goodship et al 2004, Peters 2009). The scale of central control being exerted by the coalition Government within this legislative framework emphasises the ambience of distrust previously held by the previous Labour administration. The belief that the self-interests of professionals and bureaucrats at a local level will adversely impact on realising the potential of central policy intent appeared to be a fundamental concern for the Government (Warren 2012). Whatever the rationale, these actions signal that this Government was anticipating failure from the outset and was reticent to entrust health and social care alliances at the locality level to deliver on the integration aspirations without recourse (Audit Scotland 2011).

A degree of scepticism is also noted within the related literature in regard to the organisational returns envisaged from the impending changes on partnership working and integration (Manthorpe and Iliffe 2003). The reiteration of what is primarily a macro level structural approach to public service organisational change is recognised within the body of literature as being limited (Glasby et al 2011). The emphasis upon structural change focuses energy upon internal preoccupations rather than external relationships, resulting in "cultural damage" that is rarely understood or assessed (Hudson 2011). The potential ramifications of the imminent change is considered to be detrimental in terms of eroding the established relationships within current partnership arrangements that form the basis for integrated working. These considerations legitimise the concerns that organisations will experience further fragmentation and integrated working may take a retrograde

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

step in the future. (Manthorpe and Iliffe 2003). Irrespective of the scholarly reservations arising from historical lessons, the Public Bodies (Joint Working) (Scotland) 2014 legislation is being heralded as the biggest organisational reform in the history of health and social care (Ham et al 2012).

3.4. Partnership Working: Governance, Performance Indicators and Perverse Incentives

The Third Way's public service modernisation strategy involved a redefinition of the relationship between central government and other sections of the public sector (Mandelston and Liddle 1996, Goodship et al 2004). In order to compensate for the absence of market forces, new public management reformers introduced performance indicators and numerical targets to act as proxy measures of effectiveness within public service organisations. These were used to encourage an ideology of competition and private sector principles within the fields of public services (Bevan and Robinson 2005). The redefined relationship was premised on a reconfigured power dynamic between central and local government levels. Central Government control prevailed as the overriding political requisite was to evidence results. Predetermined service performance targets were set, backed by the establishment of regulatory inspection bodies which were charged with monitoring organisational performance and redressing systemic partnership failures in achieving the centrally driven policy targets and objectives (Newman 2001).

The Joint Performance Information and Assessment Framework (JPIAF) initially introduced in 2003/04 was primarily system and process focused with an emphasis on Local Improvement Targets (LITs) that evidenced organisational performance in terms of inputs and outputs (Joint Improvement Team 2009). The revised JPIAF indicators in the following year signaled the Government's aspirations to embed the Third Way's socialist ideological element within the performance measurement structures by incorporating a person centred outcomes perspective (Scottish Executive 2003). The Scottish Government, following a considerable consultation period across Scotland and in line with the Reshaping Care for Older People policy developments, introduced the National Community Care Outcomes Framework in 2008. The intent was to provide a high level strategic composite construct that accommodated the use of pre-existing performance measures within health and

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

social care, such as the National Minimum Information Standards (NMIS) and the Health improvement, Efficiency and governance, Access, and Treatment targets (HEAT).

The use of multiple indices to populate an evaluative system designed to reflect a whole system perspective was a political tool central to the Scottish Government's intent to inject new thinking. The objective was to accelerate the integrated/partnership working agenda and capitalise on the inherent dormant capacity of the public and the community (Jacobs et al 2004). The potential of the National Community Care Outcome Framework to inform and support established local partnership policy constructs in terms of the Single Outcome Agreement (2007) and the Integrated Resource Framework (2008) were actively promoted, whilst the inclusion of additional performance measures within the strategic framework served to emphasise the increasing imperative to evidence outcomes for patients and carers as part fulfilment of performance measurement within and across services (Scottish Government 2008).

The framework's themed measures of success included anticipatory care arrangements that minimised unplanned admission into hospital or care; a specific emphasis on reduced length of stay in hospital through early and supported discharge; improved ease of patient access to community services through integrated care pathways combined with effective care coordination practices between services; and improved outcomes in terms of patient health, wellbeing and levels of patient and carer satisfaction (Shifting the Balance of Care 2009). The centrally mandated performance targets were backed by punitive powers of intervention by the secretary of state in the event of performance failure (Sanderson 2001, Goodship et al 2004); whilst the capacity for organisations to earn dispensation in the form of proportionate levels of scrutiny existed where success in achieving the standards set were evidenced. The granting of 'earned autonomy' from detailed inspection was enshrined as a central concept in the New Labour vision of public management (Hampton 2004).

Paradoxically, the Government's central governance strategy inadvertently undermined sustainable capacity building and devolved governance through local networks as its power and influence over local politics strengthened (Newman

2001). The imposition of top down structures with predefined objectives brought significant challenges in terms of perverse incentives and unintended consequences (Caers et al 2006, Thiel and Leeuw 2002). The intricacy of measuring public service activity is attributed to be due to the multiplicity and ambiguity of the goals which are frequently in conflict with one another (Jackson 2011). Targets change behaviour and the capacity for disharmony and network failure is a genuine risk as the social ties between professionals within the network are destabilised (Goodwin et al 2004). Rather than collectively focusing on achieving the system's *purpose*, individuals, departments and organisations are inadvertently placed into competition with each other. Efforts and ingenuity are focused inwardly on the target at the expense of activity not subject of targets. As Guilfoyle (2013) sums up, numerical targets cause inter-departmental rivalries, cheating, gaming, data distortions, higher costs, lower morale and, poignantly less effective public services.

Bevan and Hood (2006) propose that there are two overriding flaws in the theory of governance by targets. The first is its reliance upon 'Synecdoche'. Synecdoche is a problem arising from the multidimensionality of performance and the certainty that not all such dimensions will be measurable (Thompson and Mathys 2013). These problems of measurement are deemed as unimportant as the part on which performance is measured is considered to adequately represent performance of the whole. This supposition is misplaced as public sector performance management systems are generally regarded as containing numerous indicators and targets that are often incongruous, confusing and contradictory (Micheli and Neely 2010, Moynihan 2008).

The continued emphasis on measuring the inherently more quantifiable performance measures of inputs and outputs further curtails the realms of performance measurement to organisational processes rather than the more elusive outcome measures that provide an indication of service impact and quality (Mannion and Braithwaite 2012, Thompson 2007). Organisational processes are also often inconsistent with the achievement of the predetermined targets encouraging compromising and evasive behaviours (O'Neill 2002). Within this context, the performance paradox highlighted by Meyer & Gupta (1994) and Meyer & O'Shaughnessy (1993) describing a weak correlation between performance indicators and performance itself is unsurprising.

Demming (1986) argues for the judicious selection of performance measures, as do Bird et al (2005) and Heinrich (2008), who promote the use of evidence based performance indicators; whilst Heinrich and Marschke (2010) endorse augmenting metric measures by conducting subjective assessments of staff and tracking progress and achievement through time. Recognition of the interconnectivity of performance measures between system and agent and acknowledging the interdependency of different parts of the system is fundamental in combating the inherent weakness of synecdoche and countering the perverse incentives that contribute to unproductive interdepartmental defensive behaviours and rivalry (O'Neill 2002). The risks of responding to compartmentalised performance measurement parameters in silos and reacting to inadequate data is argued to result in learning and innovation being thwarted and waste being driven into the system. (Wheeler 2000, Wheeler 2003, De Bruijin 2007).

The second flaw in the theory of governance is the underlying assumption that governance by targets can ever be immune to “gaming” by agents (Bevan et al 2006). Governance by targets rests on the assumption that targets will inevitably influence and change the behaviour of individuals and organisations (Wheeler 2000, Bevan et al 2006). Proponents of targets envisage workforce efforts are focussed on complying with the policy directives to improve the system (Boyne and Chen 2006). Policy makers fashion policies on this assumption and expect that those who implement the policies will behave in certain ways, motivated mainly by their professional ethics and altruistic tendencies to deliver in the interests of the public (LeGrand 2003). Others argue that gaming behaviours distort the data and system, to the extent that it may engage individuals and organisations in unpalatable and unethical practices (LeGrand 2003, Seddon 2008). Professionals pursue performance targets that compromise their professional expertise and judgment about what is in the best interests of their patients. When incentives encourage arbitrary and unprofessional choices these can distort the genuine aims of professional practice, cultivating growing cynicism and damaging professional pride and integrity (O'Neill 2002).

Among the gaming behaviors identified by Bevan and Hood (2006) are the “ratchet effects”, “threshold effects” and “output distortions”. Ratchet effects describe management action to underreport performance in order to secure a less demanding future target. Threshold effects outlines instances of collective reports of performance across different functions in efforts to disguise poor individual or departmental performance, resulting in the perverse incentive of encouraging high performers to allow their performance to deteriorate to the norm; and ‘Output distortions’ ascribes to the concept of synecdoche as targets are achieved at the expense of unmeasured aspects of performance.

The perversity of gaming behaviour within public services are illustrated by a number of scholars. Hood (2006) discusses the intransigence of GP targets that resulted in adverse appointment systems whereby surgeries were reluctant to book appointments more than 48 hours in advance. Similarly, Loveday (2008) exposed examples of gaming within Accident and Emergency Departments in response to admission time targets, whilst inquiries into clinical care failings at the Mid-Staffordshire NHS Foundation Trust found that target-driven performance management contributed to avoidable patient deaths (Alberti 2009, Colin-Thome 2009). Within social care, Courty and Marschke (2004) evidenced instances where providers manipulated the timing of client exits from employment and training programmes to maximise their rewards. A national Audit Office report about the UK health service waiting lists identified nine NHS Trusts had inappropriately adjusted their waiting lists, three of them for more than three years which had affected nearly 6,000 patients records (National Audit Office 2001). The adjustments varied in their misrepresentation from staff following established, but incorrect, procedures through to deliberate manipulation or misstatement of the figures.

In effect, these case examples illustrate a range of behaviours that distort and manipulate the system through gaming activities to achieve the *measured* performance targets. Serious reservations as to the validity of claims that report dramatic improvements in performance are raised by Hood (2006) who questions whether such reports are genuine or are offset by gaming activities that result in reductions in performance and quality not captured by the targets. Fundamentally, the human dynamics and behaviours in response to performance measures provoke

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

questions as to the suitability of performance measures as a justified accountability tool within the government's governance framework (O'Neill 2002). If, as has been suggested by Thompson and Mathys (2013), performance is a process, and if measures are at best a means of gaining insight into process, then they should be understood for the abstractions they are and as such used as a focus of communication and learning but not accountability.

3.5. Partnership Working: The Evidence

The aims of integration can be multiple and the definitional mire can generate an erroneous premise from which to set criteria against which success is to be measured (Kodner 2009). The breadth and scope of the related research spans multiple organisational boundaries and service sectors as well as numerous professional and academic disciplines. Furthermore, enquiries into the effectiveness of partnership working can be counterintuitive as the measurement for success can become problematic due to competing and or conflicting criteria arising from diverse perspectives between partner agencies (El Ansari et al 2001). This is further compounded with discrete research activity adopting different research methodology across a range of different patient diagnostic populations (Reed et al 2005). As a consequence, the complexities associated with measuring the impact of efforts to achieve integration/partnership working are multifaceted and have and continue to present a significant challenge (Goodwin 2008).

An early systematic review of the factors promoting and obstacles hindering partnership working by Cameron et al (2000, pp.23) concluded that there was a "dearth of research evidence to support the notion that joint working between health and social care services is effective". Their subsequent systematic review undertaken a decade later served to reaffirm that the evidence base for partnership working remained lacking and called for more high quality, large scale longitudinal evaluations to test the underpinning assumptions of the value of the integration agenda (Cameron et al 2012). A nationally commissioned programme of evaluations undertaken by the Personal Social Services Research Unit in 2009 explored the effectiveness of joint working across 39 pilot projects within the UK reported similar conclusions. Although the results were mixed, the evidence was considered by Cameron et al (2012) to be less than compelling. The studies were considered to be

either highly descriptive or unclear as to the specific outcome to be measured; with few being comparative in design or offering a pre and post analysis following the introduction of a change measure. The studies were also almost exclusively on a small scale project evaluation level, usually in diagnostic and service specific groupings and did not generally consider a whole system analysis perspective. The available evidence within both the UK and international based integration related literature for older people would suggest that there is no significant difference on clinical outcomes, service provision, cost effectiveness or levels of staff or patient satisfaction arising from strategies to promote integrated care in practice. (Petch et al 2013)

In summary, the empirical evidence would suggest overwhelmingly that Inter-organisational partnership arrangements are difficult to manage and often fail to meet expectations (Thomson and Perry 2006); yet the perceived potential rewards of partnership working to deliver on major policy objectives prevails and the pursuit of integration as a solution to the nation's fiscal challenge retains supremacy within the policy agenda in the UK. (Sterna and Green 2005). This apparent illogical endeavour is in part fuelled by the rhetoric of partnership working which leads commentators to highlight achievements and describe failure as exceptional (Jessop 2004). The key question begs: why has the potential rewards of partnership working and integration eluded the Third Way's political ideological aspirations? Part of the problem may lie in the conceptualisation and approach taken to developing and implementing integrated care. The approaches adopted in the strategic and operational implementation of integrated care developments are within the scientific management paradigm. Health and social care organisational constructs are framed as linear and predictable, underestimating the complex adaptive systems and variables at play. The application of reductionist measures within system and process redesign presupposes that transformational change to realise the multifaceted aspirations of integrated care can be achieved through orderly planning and control processes and fails to grasp the complexities of major social system change (Tsasis et al 2012).

The complexities emerge in the contextual understanding that each member organisation has its own goals, operating context and particular approaches, which

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

can be expressed as their organisational norms, business processes and culture (Curry and Ham 2010). The unwavering adherence and rigid commitment to traditional organisational models and preferences is perceived as a contributing limitation in the pursuit of developing integrated care arrangements between health and social care. The preservation of traditional organisational policies, professional boundaries and power systems are exacerbated by the continued misalignment of health and social care manpower strategies, including a major underinvestment in human resource development. Weak and fragmented planning and knowledge systems compounded with significant deficits in leadership and management further undermine the attainment of transformational change (Boulton 2012).

The focus of collaboration is therefore reliant on a number of interdependent variables converging and interacting at multiple levels. Defining, with precision, the independent variables giving rise to the problems associated with achieving integrated care is problematic, as the origins are concealed within the inextricable interplay of a multifaceted and emergent context. As a consequence, outcomes become unpredictable as the causal relationship between action and outcome becomes obscure (Huxham 1996, El Ansari et al 2001). Unpredictability gives rise to uncertainty giving rise to organisations and individuals acting independently and in diverse directions to address the same problem.

Traditional strategic planning is viewed by Tsasis et al (2012) as flawed in its oversimplification of the organisational complexity within health and social care systems. The limitations of policy reform that focuses on structural and system change as the measure of choice in promoting integrated care arrangements are considered inadequate in underestimating the impact of inter-organisational dynamics and relationships. The ramifications of failing to instigate relationship building, trust, and alignment across organisations and professional groups circumscribes the potential for effective negotiation amongst members of collaborative groups (Tsasis et al 2012, Luna-Reyes et al 2007, Williams 2002). Failure to build trust between members or organisations, and the existence of mistrust, are barriers to collaborative success (Williams 2002). Trust, according to Harris et al (2009, pp.3), is “built over time through member interactions and is concerned with the relational bonds, such as the recognition of benevolent actions,

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

the integrity of individual members and shared values and objectives". The political compulsion to reflect tangible results quickly however, creates a dichotomy whereby an emphasis is placed on short term strategies that detract from measures to promote sustainable capacity building (Newman 2001). The organisational turbulence generated by the top down imposition of structures with pre-defined objectives (and performance measures) risks disharmony and network failure as the social ties between professionals within the network are destabilised (Goodwin et al 2004). Organisations working together must find ways of investing time to nurture collaborative relations in order to eliminate differences or mitigate their impact to reduce the risks of collaborative inertia and conflict. Strategies require to acknowledge and embrace organisational complexity in order to harness collaborative advantage (Harris et al 2009, Vangen and Huxham 2012).

3.6. Partnership Working: Organisational Complexity and Collaborative Tensions

Collaboration within inter-organisational partnerships is recognised by Huxman and Vangen (2005) as a messy, contradictory, dynamic process that is defined by multiple view points and unintended outcomes. The scholars promote the theory of collaborative advantage to provide a theoretical construct in considering the inherent complexities of collaboration. This theoretical approach is structured around a tension between collaborative advantage which refers to the synergy that can be created through joint working; and collaborative inertia reflecting the tendency for collaborative partnership activities to be unsuccessful. Collaborations are conceptualised as paradoxical in nature with inherent contradictions and mutually exclusive elements caused by inevitable differences between partners. These differences contain the very potential for collaborative advantage but can conversely generate mechanisms that contribute to collaborative inertia. The multidimensional influences and differences within a collaborative context encapsulate the inherent potential for capacity building between organisations (Gray 1989). This is, however, dependent on shared service strategies based on a mutual understanding, a collective will and a milieu of trust (March and Olsen 1989 in Thomson and Perry 2006).

Organisations that collaborate must experience mutually beneficial interdependencies based either on differing interests or on shared interests. The former scenario relates to what Powell (1990) calls “complementarities. Complementarity situations are supported by resource dependency theory and describe situations where one organisation’s power over another organisation is equal to the dependence on the respective organisation’s resources. An organisation’s willingness to forego the pursuit of their interests independently is borne from a need to secure scarce resources in terms of skills, expertise or funding to achieve an objective (Thomson and Perry 2006). This interdependency leads to uncertainty and in efforts to reduce the uncertainty, organisations form coalitions, pool resources and change their strategy to survive (Kite 2013). Although acknowledging that the diversity tension within the collaborative partnership is central to the capacity building potential, common wisdom suggests that a prerequisite to joint working is a clarity, or at least a congruence of the partnership aims if collaborative advantage is to be achieved (Vangen and Huxham 2006). The more consensus partners can forge out of differences based on each other’s needs, the greater the likelihood they will be able to collaborate. Mutuality and a shared will for collaboration originates from shared interests and is usually based on homogeneity or an appreciation and passion for issues that go beyond an individual organisation’s mission e.g. similarity of mission, commitment to similar target populations, or professional orientation and culture (Lax and Sebenius 1986).

Common practice, however, appears to be that the variety of organisational and individual agendas that are present in collaborative situations makes reaching agreement difficult (Huxham and Vangen 2004). The reasons behind the struggles for agreement may not be obvious. Organisations and individuals have different reasons for being involved, and whilst some are articulated openly and may be genuine statements about what they aspire to achieve, others are unstated, circumspect or hidden (Huxham and Vangen 2004). The authenticity, status and relevance of the collaborative aims varies in accordance with each stakeholder’s perspective (individual and organisational), resulting in different levels of commitment. The different expectations, aspirations and understandings of what is to be achieved jointly, coupled with variations in levels of personal and organisational commitment create tensions that cause confusion, misunderstanding

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences and conflicts of interest. (Huxham and Vangen 2004). Negotiations among competing interests and brokering coalitions among competing value systems, expectations and self-interested motivations undermine partnership agreements as each strive to preserve their cultural norms and deliver on their respective individual organisational objectives (Thomson and Perry 2006). Culture, in this context, is used broadly to refer to partners' "habitual ways of being and acting" (Vangen and Winchester, 2014, pp.686) that stem from the distinct professional and organisational cultures to which they belong. Organisations in collaboration accommodate different structures, procedures, different communication channels, etiquettes and practice norms. The cultural essence is expressed through the organisation but constituted through the interaction and practice of the workforce through their culturally embedded perceptions, behavioural characteristics and professional expertise.

These variables are oriented towards internal purposes rather than the aims of the collaboration specifically. Organisational representatives have to respond within cultural contexts that are not designed nor conducive to collaborative endeavours, creating cultural frictions at the inter-personal level (Vangen and Huxham 2004). Employees within organisational networks experience tension between personal autonomy and accountability to their employing organisation. Collaborative activities affect the parent organisations and as such employees seek permissions to deviate from established organisational procedures and norms in order to participate in collaborative activities. The diametrically opposed positions of organisational flexibility to accommodate collaborative activity and rigidity to reserve organisational interests and integrity encapsulates the tension within collaborative endeavours to accommodate diverse cultures (Huxham and Vangen 2005). During this process increasing levels of complexity arise from multiple, diverse, and at times competing variables located at multiple levels. The limits of human capacity to balance multiple expectations, activities and goals diminish and the impetus for the proposed action wither as employees have limited amounts of time, energy and enthusiasm for working together, even if they believe in a common cause such as continuity of patient care. Initial enthusiasm may dissipate and give way to less productive characteristics including rivalry between different members of the partnership,

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

fragmentation and/or duplication of effort, emergence of disruptive hierarchies, or diminishing commitment and access to resources (Lowndes and Skelcher 1998).

Mutuality, trust and reciprocity are cited as the key variables within a collaborative partnership that creates opportunities to counteract partnership's diminishing commitment to collaboration and behaviours that lead to collaborative inertia (Tsanos et al 2014). These can be conceptualised in two different ways: one that is short term and contingent and one that is long term and rooted in a sociological understanding of obligations (Axelrod 1984, Ostrom 1990, Powell 1990). Individual partners' willingness to interact collaboratively is governed by the norm of reciprocity, where Lewis (2008) observes that partners share an expectation that each will discharge their obligations within the realms of the collaborative endeavour and will refrain from unscrupulousness actions in pursuit of advantage over the other (Lewis 2008).

For Ostrom (1998), the reputation of partnerships, developed through the reciprocity over time, builds the basis for a trustworthy inter-organisational context. Within this context, the reciprocity behaviour can shift from the contingent formal organisational partnership agreement to longer-term commitments based on "psychological contracts" as personal relationships supplement formal organisational agreements (Ring and Van de Ven 1994). To establish such relationships through trust building requires an inordinate amount of time and energy at an organisational cost of low productivity during the process; which presents specific challenges within a performance measurement regime. (Huxham and Vangen's 2005). The emphasis on repeated interactions in the game theory literature underscores the social and cultural tenets that form the basis of social interaction and gives reciprocal exchanges meaning (Powell 1990). This cyclical process of negotiation and compromise facilitates successful collective action afforded by opportunities for resource sharing and practice based learning (Lewis 2008, Axelrod 1984). The degrees of mutuality, trust and reciprocity are however contingent on the distribution of authoritative resources; that is, the distribution of access to positions of power and authority (Lewis 2008). The reciprocity continuum as described by Lewis (2008) spans situations where there is an equilibrium in terms of reciprocity to cases where there is a disproportionate imbalance. In instances where the imbalance of

reciprocal rights is extreme, the term 'trust' is not authentic (Lewis 2008, Hardy 1985, Hay 2002). The appearance of collaborative behaviour in such situations may be as a consequence of an absence of viable alternatives for those partners who are dominated by those in positions of power (Lewis 2008).

An important characteristic of power within collaborative ventures is that it is not static and continually shifts. Power is relational, situational and potentially mutual (Pfeffer and Salancik 1978). At the macro level, the Government's political policies and strategies, backed by governance arrangements, as previously described, determine the strategic direction and objectives to be fulfilled at the meso-service level in locality, whilst the interpretation and implementation parameters of these policy directives are shaped by managers in locality. The continuous shift of power exerted by practitioners at the micro level, although less obvious, is substantial at all levels (Lipsky 2010). This is a point of significant relevance to this thesis which will be explored in further detail in section 3.5 when examining Lipsky's concept of street level bureaucracy. The jeopardy arising from a significant imbalance of power and reciprocal rights within a partnership, according to Lewis (2008), is that the process of communication through which relations of trust evolve are distorted. Unequal access to resources and position of authority shapes the construction of meaning within the partnership whereby the interpretation of what constitutes the fair distribution of rights and obligations is largely determined by those in positions of advantage. Hardy et al (1998) suggest that this creates a façade of spurious trust as those in positions of advantage promote their vested interests at the expense of the welfare of the other participants in the relationship.

The distinction between cooperation based on genuine trust and cooperation based on a façade of trust has significant operational ramifications. Cooperation based on the façade of trust may suffice where the organisation require the mechanical implementation of a given task or procedure. However, the goal of harnessing the energy and initiative of personnel within partnerships to create new knowledge and novel capabilities requires a culture of genuine trust (Nonaka and Takeuchi 1995, Hardy et al 1998, Osterloh and Frey 2000). Participation in relations of genuine trust involves relinquishing control and experiencing a degree of uncertainty and vulnerability as the responsibility for the performance of tasks is placed in the hands

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences of others. Dominant partners may prefer to use power rather than trust to ensure cooperation because the greater predictability associated with the former offers more immediate and calculable benefits than the uncertain rewards associated with genuine trust and reciprocity (Hardy et al 1998)

Given the challenges inherent in collaborative contexts, characterised by incongruent goals, lack of trust, cultural diversity, paradoxes and tensions, prevalent leadership approaches that are centred on the formal senior figures are likely to be found inadequate in collaborative context (Vangen and Huxham 2003). Collaborative leadership ideologies promote the adoption of sophisticated and advanced *sense making* capacities that deliver beyond technical problem solving which have established techniques to address them (Stensaker and Falkenberg 2007). The emphasis in collaborative leadership development strategies is to democratise leadership development and capacity within and across organisations. The imperative is to foster a collective leadership process that is spread through networks in efforts to respond and capitalise on the differences and interdependencies of collaborative working. This is to be achieved through aligned leadership mechanisms that engender shared ownership, power and control in the delivery and development of collaborative services (Archer and Cameron 2012).

Leadership in collaboration thus implies facilitative activity suggesting the need for relational skills such as patience, empathy, honesty and deference. However, to overcome the inevitability of working with partners who have different needs, values, perceptions and varying levels of commitment, those enacting leadership may engage in directive rather than facilitative roles (as per central government's governance arrangements outlined in section 3.4, manipulating agendas and politicking to avoid stagnation and collaborative inertia. Imposing an understanding of collaborative issues on others and influencing the agenda via surreptitious behaviour is viewed by Vangen and Huxham (2003, pp.72) as necessary tactics. They maintain that political manoeuvring is often strongly evident in collaborative activities and that activities to exclude partners who are not "worth the bother" whilst identifying and enticing others through incentives is routine in the reality of collaborative ventures. The essence of enacting leadership for collaborative advantage would as Vangen and Huxham (2003, pp 22) propose,

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences involve the intelligent application of leading in the “spirit of collaboration” whilst simultaneously drawing on “collaborative thuggery” as circumstances dictate.

Building on the complexities of measuring outcomes arising from partnership or integrated working within a stratified context as intimated in section 3.5, many of the difficulties of researching collaboration and collaborative advantage similarly stem from the fact that their antecedents and consequences may be located at multiple levels and can emanate from within the collaborative constructs themselves (Foss and Nielson 2012). The framework recognises the spectrum and interplay of structural and agentic variables that energise and constrain those engaged in collaborative activities within a stratified context (Williams et al 2009, Thomson and Perry 2006). These dimensions, though distinct variables, are interdependent in the sense that movement from one dimension to another does not necessarily occur sequentially. Instead, the dimensions are part of a larger covariance model in which variation across each dimension is influenced by variation in the others. Movement along the dimensions depends on a wide variety of factors, including but not limited to internal relationships (Bardach 1998, Huxham and Vangen 2005, Ospina and Sag-Carranza 2005, Sink 1996, Williams 2002) and antecedent conditions such as uncertainty, ambiguity, shifting membership, and multiple accountabilities (Huxham and Vangen 2000, Ospina and Sag-Carranza 2005).

The inherent complexity within the dimensions renders the task of linking inputs to outputs as problematic and researching collaborative advantage inherently requires a multilevel approach (Foss and Nielson 2010). Theoretically, due consideration of antecedents and consequences at different levels, as well as potential cross-level effects is lacking within existing research. Researchers have devoted little effort to defining the level at which constructs operate or to developing theory within the strategic alliance field to explicitly address the role of variables at different levels (Foss and Nielsen 2010). Furthermore, the somewhat contradictory nature of the related research messages on outcomes has led in recent years to arguments for a more nuanced approach. The focus it is suggested should be on “which mechanisms work for whom, and within which contexts” (Dickinson 2006, pp 379). Continuity of care is concerned with the quality of care over time and can be considered from a patient and/or a service perspective. Continuity of care conceived from a patient's perspective refers to the patient's experience of a longitudinal

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

relationship with a professional built over time, and relates to patients' satisfaction with both the interpersonal aspects of care and the coordination of that care. From a vertically integrated service perspective, continuity of care relates to the delivery of a seamless service through information sharing and care coordination between different organisations. The emphasis is on responsive models of service delivery that deliver improved outcomes. These differing perspectives are referenced by Gulliford et al (2006), who acknowledge that patients' care needs are rarely met by a single professional and suggest that multidimensional models of continuity have to be developed to respond to the differing perspectives simultaneously.

3.7. Partnership Working: Transitional Care and Continuity of Care

Today's health care systems are overly devoted to dealing with acute, episodic needs and there is an absence of a cohesive multidisciplinary care infrastructure to deliver the full complement of services and supports needed by the rising number of older people with chronic conditions (Corrigan 2002). Care is circumscribed by the setting at the point it is being delivered, and little attention is paid to considering the care plan formulated prior to admission or post discharge (Coleman 2003). The different financial and contracting arrangements between settings serve to determine the independent priorities pursued by the separate organisations promoting silo operations. Further, the rapid pace of scientific discovery and technological innovation, accompanied by specialisation has increased the numbers of practitioners and settings involved in the care process. This has compounded the complexity of navigating the maze that is the health and social care system (Corrigan 2001).

Public services have increasingly been structured and delivered on the basis of specialities, workforce, departmental and management categories and have culminated in the perverse outcome of making health and social care services less personalised (Donaldson 2001). Practice arrangements are shaped whereby staff relinquish the historic longitudinal approach to care to curtail practice essentially to the organisational parameters of the employing body. Patients are transferred across settings receiving limited care from multiple services and personnel. As a consequence, current health and social care services provide older people with chronic or multiple pathologies with care from a variety of practitioners within

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

multiple settings. The delivery of care is often overly complex and uncoordinated, requiring numerous steps and transitions of care between services (Coleman and Berenson 2004).

3.7.1. Transitional Care

Transitional care can be considered a part of integrated care and is internationally recognised as a major quality improvement challenge (Reed et al 2005). The scale of the issue in Scotland is reflected within the ISD (2000) statistical analysis. These illustrate that the prevalence of transitions of care among older people in receipt of health care within Scotland is on the increase with the number of total of these transitions 52.6% (342,179) were from hospital to home, 16.7% (77,864) were to other specialities within the hospital, whilst 0.5% (2,496) were to local authority care. The ramifications of increasing transitions in care is discontinuity of care. Discontinuity of care raises questions as to the effectiveness of intervention, puts patients at risk, causes duplication and generates additional costs to both health and social care (Kohn et al 1999, Haggerty et al 2003, Freeman and Hughes 2010). The resulting standard of care received by many older patients is unacceptable and the poorly planned and executed handover of patients within and between services is reportedly dehumanising (Levenson 2007, Goodrich and Cornwell 2008, Francis 2010, Abraham 2011). Preventable adverse events, including medication errors, falls, errors in diagnosis, post-operative infections, confused states and hospital readmissions are risks for older people during care transitions, particularly those with functional difficulty and chronic illness (Laugaland et al 2012, Mansah et al 2000).

Ironically, the endeavour to achieve the efficient use of resources is misguided as striving to meet the organisational priorities at the expense of patient care fails from both a human and financial perspective (Glasby et al 2011). Coleman and Boulton (2003) define transitional care as a set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or between different levels of care within the same location. Patient handover is a critical element in transitional care and involves not only the transfer of information but also the transfer of professional responsibility and/or accountability between

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences
practitioners, teams and organisations engaged in the patient's care (Jeffcott et al 2009).

3.7.2. Continuity of Care.

Continuity of care is a multifaceted concept that is defined and operationalised in different ways by different scholars but is acknowledged as the process of achieving quality care outcomes in the context of transitional care (Freeman et al 2002). Existing related literature on continuity of care is almost exclusively restricted to the primary health care service sector, with a particular emphasis on GP services. As a result, definitions of continuity of care typically reflect the health service organisational perspective, but the definitions offered by Haggerty et al 2003, informed by a systematic review of the literature, are deliberately engineered to be applicable in multiple specialities and care settings and are of particular relevance within the context of this research which considers the interface of patient care between health's Acute and Primary care settings and the Local Authority's social work service.

Definition: Continuity of Care

Informational continuity: The use of information about the patient's medical condition, past treatment, and personal circumstances (including care preferences) to deliver the most appropriate care for each individual/family.

Management continuity: A coherent approach to the management of a health condition achieved via a consistent and flexible management plan that is accepted by all providers and the individual/family.

Relational continuity: A consistent therapeutic relationship between the individual/family and one or more providers; access at all times to a provider who "knows" the patient/family.

Haggerty et al 2003

The relevance attached to each type of continuity as defined by Haggerty et al (2003) is shown to have different perspectives. Each can be viewed from either a patient (and carer) focused or an organisational focused perspective. This perspectivist understanding of continuity of care suggests that there are no ethical or

epistemological absolutes and there are many possible conceptual schemes or perspectives in which judgement of truth or value can be made. Haggerty et al (2003) identify two qualifying attributes within continuity which differentiates continuity of care from other care attributes. The first is care of an individual patient and the second is care delivered over time, both of which need to be present for continuity of care to exist. The first element, care of an individual patient, helpfully distinguishes continuity of care from a patient's perspective from that of service coordination and integration. The second element, care over time, has been identified consistently as a longitudinal or chronological dimension of continuity. Time distinguishes continuity from other attributes such as the quality of the interpersonal communication during a single episode of service intervention. The authors conclude that unless the mechanisms through which care delivered over time improves outcomes are understood, continuity interventions may be misdirected or inappropriately evaluated.

As part of a conceptual evolutionary understanding of continuity of care within this study, Freeman et al's (2000) multi-axial conceptualisation of continuity of care is considered. It emphasises the sovereignty of the patient's perspective through the concept of "experienced continuity" and formulates the other key constructs of continuity as process derivatives to fulfil the patient's positive experience of care i.e. *cross-boundary, flexible, information, relational* and *longitudinal* levels of care. In prioritising the patient's point of view, it is acknowledged that patients have preferences and priorities determined by personal values that shape their perspective on the valued components of continuity of care. Nutting et al (2003) highlight continuity of care might be differentially important for different types of patients during different types of interventions. Vulnerable populations by dint of age, chronic disease or socioeconomic status were shown to value continuity of care more. The experience of a 'continuous caring relationship' with an identified professional who case manages their care (advocating for their preferences and choices in respect to their treatment and care) is considered to depict the valued features of continuity of care from a patient's perspective.

The potential hazards and limitations of patient's satisfaction levels as an isolated measure of continuity of care are highlighted by Freeman and Hughes (2010) as

they reflect on the propensity of patients to be satisfied with care that is of poor quality and not evidence based. The measure of liking or trusting the professional engaged in their care (relational) might well be precisely what makes patients feel their care is of high quality even when it is not. Ironically, consistent contact with a suboptimal practitioner might be far from desirable and 'obligatory longitudinal continuity' could impair the quality of care. Furthermore, the efficacy of the measures in practice to achieve both the informational and management elements of continuity can only be presumed by patients. Communication and coordination is inferred when no problems have occurred: only patients who experience care management glitches that result in discontinuities express dissatisfaction (Woodward et al 2004). Likewise, patients seldom observe the negotiation of roles and complementary actions among different professionals within their efforts to fulfil management continuity of care on behalf of the patient. Again, role clarity can only be assumed until proven otherwise as discontinuity enters the patient's awareness as different practitioners work at cross-purposes or when care is compromised because of lack of coordination or communication (Wallace et al 1999).

Continuity of care can thus be argued to be both a process and an outcome within a context determined by its relationship to other constructs. The process element is described by Belling et al (2011) as relating to specific interventions and approaches performed by public service personnel that results in an outcome. Whether the 'experienced continuity' outcome by patients is positively achieved or not depends on how well services perform on particular dimensions that contribute to this experience. Examples of processes related to continuity of care are described as procedures associated with patient assessment, transfer of information and discharge planning and include the implementation of systems for effective information transfer within and across organisational boundaries. The effective coordination of management services by teams and the deployment of professional staff to remove disjointed episodes of service delivery that exert a positive impact on care outcomes are also advocated; as are the development of responsive systems and processes to provide care adequate to meet the patient's needs over time that are underpinned by effective monitoring infrastructures. These process strategies serve to develop accountability structures where the "collusion of anonymity" as described by Balint (1957, pp.93), is mitigated against and therapeutic relationships

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

can be established. Practitioners assume their duty of care and practice beyond the contemporary predefined and circumscribed service parameters, facilitating patient security and trust in the relationship with the practitioner.

Heaton et al (2012), acknowledge the process of continuity of care but suggest that the outcome is co-constructed by patients and professionals. They propose a “partnership” paradigm where both stakeholders are deemed as having an active part to play in accomplishing continuity. The patient’s agency in defining and assessing continuity of care is accentuated and the professional monopoly in defining the parameters of service continuity is contextualised. Continuity of care is acknowledged as a product of the relationship between the patient and the professionals engaged in their care. As such, the critical role of patients and professional staff in continuity of care is recognised and the efficacy of continuity of care is portrayed as contingent on the dynamic micro level exchange within this relationship. This differs from the idealised meso-level process related system solutions generated to promote continuity of care, such as care or clinical pathways, care management or care programme approaches (Haggerty et al 2003, Hill and Freeman 2011). The positive impact on patient care is said to be developed through this relationship and the potential to deliver flexible care plans that provide seamless care to meet needs over time. The policy reform context has raised a number of challenges for delivering on continuity of care from a professional and organisational perspective. The *continuity of care* concept is closely affiliated with the transitional care ethos, both of which are embedded within the partnership/integration policy framework (Hardy et al 2005). As such, the challenges dogging continuity of care are synonymous with the challenges of partnership working and integrated care.

The obstacles are rooted in factors deeply embedded in the current design of the health and social care system and the priorities of the commissioning strategies. They affect the volume of work, the ordinary routines that govern the working days (and nights), the culture of care within public service organisations as a whole and within discrete teams, the value bases of staff and the levels of training and skill of the workforce. Issues connected with a range of communication, co-ordination and decision-making difficulties within this context were identified as being attributed to limited resources and a lack of professional capacity and time (Rogers and Pilgrim

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences 2001), bureaucracy (Dept of Health 2006), and insufficient leadership (Bosanquet and Kruger 2003). Saultz et al (2012) reflect on the potential professional and organisational consequences of continuity of care, illustrating both positive and negative characteristics. The authors purport that the practitioner's deeper understanding of, and connectivity with patients through relational continuity contributed to an enhanced sense of professional competence. Longitudinal practice strategies were reportedly adopted that personalised and enhanced patient care, the results of which provided practice variety and coherence and professional intellectual stimulation and satisfaction (Schultz et al 2012).

In stark contrast however, their study also depicted poignant professional and organisational ramifications that were not conducive to the implementation of effective continuity of care strategies. These included recorded incidences of professional distress anxiety, grief and frustration arising from the implementation of measures designed to promote continuity of patient care. The suggestion was that the responsibility of the interdisciplinary aspects of continuity rendered practitioners with a sense of being overwhelmed and professionally inept. The extended knowledge base required to accomplish care that transcended professional, service or organisational parameters was considered onerous and created concerns over loss of professional identity (Saultz 2013, Fakhoury and Wright 2004). Furthermore, the emotional investment required by practitioners to fulfil the interpersonal dimension of continuity of care was described as exhausting as the patient's expectations on the relationship continued to increase as it developed over time. This relational dynamic was viewed as having the potential to culminate in a loss of practitioner anonymity with an associated erosion of professional work/life boundaries (Kerr et al 2012).

3.8. Theoretical Critique and Debate: Framing the Partnership Challenge from a Sociological Perspective

International experience and research on partnership working and integration within health and social care have been challenged by the complex systems in which integrated care is enacted. The system complexities, outlined in sections 3.4 to 3.6 suggest prevailing bureaucratic environments, predicated on command and control approaches to policy development, management, governance and evaluation that is

ill-equipped to incentivise, support and sustain collaboration among professional and organisations. (Tsasis 2012). This section will consider the central sociological theoretical dichotomies of subjectivity and objectivity, structure and agency and synchrony and diachrony. The contemporary theories of structuration and morphogenesis are also considered reflecting the conceptual imagery and analytical analogies that sociologists use to describe the complexity of social processes.

3.9. The Three Dichotomies of Sociological Enquiry

Contemporary sociological theory inherit three predominant theoretical problems which centre on how to link the three dichotomies of subjectivity and objectivity, structure and agency and synchrony and diachrony (Archer and Tritter 2000). The first deals with *knowledge*, the second with *agency* and the last with *time*. Sociological theorists have also deliberated on the epistemological issue of transcending the divide between micro, meso and macro social phenomena and instituting theoretical specifications that explain the dynamic relationships within and across the stratified levels of reality (Kent 2013, Alexander et al 1987, Wiley 1988). The stratified levels of reality at the “empirical”, “actual” or “real” are fundamental in conceptualising and comprehending how the powers which operate in different sites and /or at different hierarchical levels relate. This depth ontology differentiates between the *empirical* as being what is perceived as being the case; the *actual* denotes the events that occur in space and time that may be different from what is perceived; and finally, the *real* which comprises of the mechanisms and structures which reflect the reality, irrespective of human knowledge of it (Edward et al 2006).

3.9.1. Subjectivity and Objectivity

Subjectivity and objectivity represent polarised paradigms within the field of sociological enquiry. Subjectivity is aligned with terminology such as “agency”, ‘subject’, ‘individual’, ‘spontaneity’, and is embedded within the micro levels of enquiry, whilst objectivity is characterised with the vocabulary of ‘structure’, ‘object’, ‘totality’, ‘determinism’ and is situated within the macro levels of analysis. These terms reflect the essence of the dichotomy underpinning the ontological and epistemological disparate positions. The distinctive approaches structure the thinking and deliberation of social reality and predicate the methodology applied to either subjective accounts or objective measures of social phenomena

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences (Greiffenhagen and Sharrock 2008). Phenomenology, symbolic interactionism or ethnomethodology are considered as paradigmatic examples of subjectivist sociology, since they place the emphasis on actors' 'subjective' interpretations, neglecting the relevance of macro-structural phenomena to sociological understanding. In contrast, objectivist approaches such as marxism, functionalism or critical theory, favour the adoption of an external or transcendent perspective and as such disregard actors' personal or individual experience. Subjectivists claim that how the social world *appears to the individual* is the only legitimate topic for the social analyst to study. This is the only reality; anything else is an artificial construction of sociologists (Layder 2006). Conversely, objectivism assumes that social reality cannot be reduced to subjects' experience of it as it relegates enquiry to mere appearances; whilst neutral, external and scientific objectivists have access to reality (Greiffenhagen and Sharrock 2008). Both subjectivism and objectivism have been criticised for their reductionism, and theorists have increasingly questioned the mutual exclusivity of subjectivist and objectivist terminologies. Contemporary sociological positions have become less clear-cut than in the past. Advocates of methodological and ontological individualism are now inclined to take into account institutions and social structures as macro constraints upon individual action (Hedstrom and Ylikoski 2010); whilst macro-sociologists seem more inclined than in the past to recognise the need to combine macro societal analysis and generative mechanism-based explanations (Manzo 2007).

3.9.2. Agency and Structure

Giddens' "theory of structuration" responds to this micro versus macro challenge by combining the two major schools of sociological enquiry; those predominantly concerned with structure - structuralists and functionalism; and those predominantly concerned with agency - hermeneutics and phenomenology (Giddens 1984). In Giddens' theoretical "duality of structure" framework, the actions of human agents discursively and recursively form the sets of rules, practices and routines which, over time and space constitutes his conception of structure. This is the process of 'structuration. The balancing of agential and structural dynamics are subdivided into three dimensions; structure, modality and interaction. The recursive nature of these dimensions is connected by the linking modalities of communication, interpretation

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences and signification. As human actors communicate, they draw on interpretative schemes to help make sense of interactions. The individuals' interactions always occur in a micro-level context but those interactions reproduce and modify the interpretative schemes which are embedded within the social structure (Giddens 1984). The distribution of power rights to various allocative (material) and authoritative (control of other people's behaviour) resources are established within these interactions, producing the social structures of domination and moral codes of sanctioned norms as the agent's actions constantly produce, reproduce and develop the social structures which both enable and constrain them (Giddens 1984). As patterns of action embed throughout society and endure over time, macro-level social institutions may then be discerned as independent form the micro-level contexts in which the actions occurs. Giddens recasts the two independent sets of phenomena (dualism) of structure and agency as a 'duality' - two concepts which are dependent upon each other and recursively related. As Giddens (1984,pp.14) asserts, "we create society at the same time as we are created by it".

The main critique of the structuration theory is centred around the 'conflation' of structure and agency (Archer 1996, Barley and Tolbert 1997). Conflation "concerns the problem of reducing structure to action (or vice versa) and the consequent difficulty of documenting an institution apart from action" (Barley and Tolbert 1997, pp.9). Giddens' structuration theory conflates the agent with the system. Archer (1996) proposes that conflating structure and agency weakens their analytical power and suggests that it is necessary to maintain the analytical distinction between the 'parts' of society and its 'people'. She believes that human actions are short term and structures enduring, which in turn allows for their analytical separation. Archer's focus is on *morphogenesis*, the process by which complex interchanges leads to structural elaboration which either reproduces or transforms the initial structure. The theory emphasises that there are emergent properties of social interaction that are temporarily separable from the actions and interactions that produce them. Once these structures have emerged, they react upon and alter action and interaction. Archer has developed her own distinctive approach through a theoretical synthesis that tightly integrates the affiliated complementarities of the morphogenetic systems theory of Walter Buckley, the functionalist Marxism of David Lockwood and the critical realism of Bhaskar into a unified morphogenetic social theory. Central to the

theory is that of the agent being pivotal in all that is social, though not the only generative element within society. Archer's morphogenetic approach's theoretical trajectory begins at a personal level, conceptualising the uniqueness of human persons and thereafter begins its "re-ascent" into the social world of positions, roles, organisations, institutions, and, eventually, the global social system.

3.9.3. Synchrony and Diachrony

"Social change travels in space, but time is necessary, not only as a means for observation, but also as a facilitator for progress" (Lee, [no date]. pp.5). Social change is time dependent in terms of enabling the structural change to unfold, but also clearly constructed in the moment of action. The relevance of incorporating the synchronic and diachronic perspectives as conditions within the theoretical enquiry is premised on the temporality of social transformation within a service redesign programme, as is the subject of this thesis (Lee, [no date].). The epistemological perspective adopted influences the research design and approach.

Lee's [no date] differentiation between how Giddens' structuration theory and Archer's morphogenetic approaches incorporates time into their respective sociological theories emphasises the fundamental distinction between the two approaches. The duality of structure and agency within the theory of structuration attempts to transcend the synchronic and diachronic dichotomy as the duality is in a constant actualising process of being reproduced and transformed. As structuration is a process of recursive social practices which are considered concurrently there is no distinction that suggest a separation of analysis between structural or agential time. The duality of structure and agency allows for different timescales to be dissected *in the moment* to see the forces acting on it. (Lee, [no date].). A synchronic approach therefore does not attempt to make deductions about the progression of events that contributed to the current state, but only analyses the structure of that state,

In contrast, Archer's (2010, pp. 238) proposition is that time is an actual variable in theory and that structure and action operate over two different time periods as

“structure logically predates the action(s) which transform it” and “structural elaboration logically postdates these actions”. Structure and agency are thus analytically distinguishable as they are phased over different bands of time. This enables the formulation of practical social theories that acknowledges that social transformation is founded on a sequential, chronological progression of complex and multifaceted phases, involving continual structural and agential interaction over time (Archer 2010, 1995).

3.10 Mechanism and Macro, Meso and Micro Levels of Analysis

The conceptualisation of the fundamental morphogenetic and morphostatic forces operating at the micro, meso and macro levels of analysis, suggests that the constitution of the society is generated from these forces and that the goal of sociological theory should be to develop an understanding of the dynamics with and between the forces (Turner et al 2005, Bruhn 2007, Archer 1995). It is in this latter concern with the relationships among the structures formed at each level that linkages among the macro, meso and micro occur. Mechanism based theorising approaches search for recurrent concatenations of mechanisms into more complex processes. This process is achieved through differentiation and aggregation. Whilst the process of differentiation defines and isolates component variables within a context; re-aggregation highlights identified relationships, connections and interdependencies in the phenomenon of interest (Archer 1995).

Mechanisms can operate as the analytical conduit that runs from macro to micro, explaining the effects of organisational socialisation practices or compensation systems on individual actions; micro to micro, reflecting social comparison processes; or micro to macro illustrating how cognitively limited persons can be aggregated into a smart bureaucracy (Anderson et al 2006). Although concerns exist that the concept of mechanisms hasn't been as well defined as it should be (Mahoney 2001), exponents of analytical sociology are advocates for mechanism based theorising within the social sciences (Hedstrom and Swedberg 1998). Pawson and Tilley (1997) have defined mechanisms as underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest. As mechanisms are underlying, they are often unobservable or ‘hidden’ (Pawson 2008). This captures the concept that social regularities (or programme

outcomes) cannot be exclusively explained by empirical level observations. Enquiry must go below the “domain of empirical,” surface level descriptions of constant conjunctions and statistical correlations to identify the underlying mechanisms that account for “regularities in the joint-occurrence of events” (Bhaskar 1975, pp. 13; Pawson 1989, pp. 157).

A key feature of a realist understanding of mechanisms is that mechanisms are sensitive to variations in context, as well as to the operation of other mechanisms in a particular context. The implication of this logic is that mechanisms should not be seen as universal “covering-laws” that apply consistently in all situations, but rather as a sociological theorising tool to develop middle-range theories that explicate the observed relationships between explanans and explanandum (Hedstrom and Swedberg 1996). A key contextual aspect of the operation of mechanisms in the social world is human interpretation of social structures and events. Whether the causal “tendencies” of a particular mechanism are activated is largely dependent on human reasoning and volition. Mechanisms work through human agents who have the capacity to think and act in terms of causalities that produce context specific outcomes. In practical terms, “programs only ‘work’ if people choose to make them work and are placed in the right conditions to enable them to do so” (Pawson & Tilley 1994, pp. 294).

This inherent capacity to generate outputs or outcomes reflects the third characteristic of mechanisms. The assertion that unobservable causal entities, i.e. mechanisms, produce effects, differs considerably from standard depictions of causation promoted by experimental evaluators who believe that causation can only be inferred by examining patterns of regular contingent relations between events. Causality is limited to that that is directly experienced and anything beyond is discredited as metaphysics (Hume 1739). In contrast, generative accounts suggest that analysis of causation occurs at stratified levels of reality. Mechanism based explanation focuses not only on outcomes themselves, and whether evaluators actually observe them happening, but also the underlying generative mechanisms that produce the outcomes. Social programmes, then, consist not just of what we observe but also of interactions between mechanisms and contexts, which account for the outcomes (Pawson and Tilley 1994).

In recent years, there have been some preliminary attempts to group mechanisms into common categories. For example, building on James Coleman's (1990) classic macro–micro–macro model of social action, Hedstrom and Swedberg (1998) suggest that there are three interrelated types of mechanisms:

- (a) situational mechanisms; (b) action-formation mechanisms; and
- (c) transformational mechanisms.

Situational mechanisms operate at the macro-to-micro level. This type of mechanism explains the influence of macro forces on micro level phenomena. For example, how specific social situations or events shape the beliefs, desires, and opportunities of individual actors. Action-formation mechanisms operate at the micro-to-micro level. This type of mechanism links individual cognition to behaviour; i.e. how individual choices and actions are influenced by specific combination of desires, beliefs and opportunities. Leon Festinger's (1957) theory of cognitive dissonance illustrates different types of action-formation mechanisms that are used by individuals to reduce psychological distress that often arises when a person holds two contradictory ideas simultaneously. (This concept will be explored more fully in section 3.12). Transformational mechanisms operate at the micro-to-macro level and show how individuals, through their actions and interactions, generate macro-level outcomes. Examples of this phenomena include "cascading," by which people influence one another to the extent that people ignore their private knowledge and rely instead on the publicly stated judgments of others. The "bandwagon phenomenon"- the tendency to do (or believe) things because many other people do (or believe) is related to this, as are "group think," the "common knowledge effect," and "herd behaviour" (Elster 2007).

McAdam et al (2001), Campbell (2005) and Stinchcombe (2002), to name but a few scholars, provide alternative mechanism typology. Each are oriented toward their specific field of interest e.g. contentious politics or the study of organisations and social movements, but are arguably applicable within other social contexts and policy arenas. Although not exhaustive, they illustrate the shape of the domain and indicate the prevalence of the mechanism based approach. Indeed, Tilly (2001), on contemplating competing approaches to theory based explanation, suggests that

causal mechanisms are an implicit feature within each methodology. As case in point, his review illustrates that equilibrating mechanisms, although notoriously difficult to identify, appeal to system theorists; whilst cognitive mechanisms are incorporated within propensity explanations e.g. sacrificing and rationalising; and the search and identification of underlying mechanisms that cause broad empirical uniformities underpin covering law explanatory accounts.

Sayer (2010), disputes that this is a representation of how causality operates. The contention relates to the assumption that social phenomena can be explained through a series of closed, linear systems and causality effectively treated as non-complex. Social phenomena are presented as being the product of multiple, interacting tendencies within an open, emergent, self-organising system, with causal powers that may not necessarily be observed or even realised. The limits to the generality of mechanism based theorising to that of a process that captures the probabilistic nature of how and why two variables covary are clarified as their properties are described as not being like deterministic laws of physics.(Hernes 1998). The temptation is to focus too much on input-output relationships, on linear chains of causality and on identifying mechanisms and assembling them into causal models that are neither interesting nor generative. Mechanisms “are usually specified in relation to and often only make sense as part of a larger body of theory. They elaborate, sharpen, transpose, and connect theories, but they do not substitute for them” (Weber 2006, Edwards et al 2014). Weber (2006) warns against the inherent risks of mechanism based theorising and the allure of replacing substantive social and behavioural science theory with a focus on putative mechanisms to explain phenomena of interest. Notwithstanding these reservations, organisational research devoid of mechanism based theorising cannot present theoretical contributions as the explanation of the connections among phenomena is limited to empirical level regularities (Sutton & Staw 1995). Social mechanisms are the explanations of how the components of a theory interrelate (Elster 1989); a necessary, but in many cases, absent aspect of organisational theories (Sutton & Staw 1995, Weick 1989).

3.11. Macro-Micro Mechanisms: Street Level Bureaucracy

The theoretical concept of “Street Level Bureaucrat” postulated by Michael Lipsky (1980, 2010) provides an insightful account of the agency of public service workers

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences within a bureaucratic structural context. "The pervasive contrast between central government's partnership working policy in theory, and policy in practice as outlined in section 3.5, is attributed to the cumulative effect of street level decisions made routinely by practitioners. Lipsky's proposition resonates with the agency/structure sociological debate by stressing the *agency* of street-level bureaucrats in exerting significant influence in the implementation of public policy. The subjective interpretation of policy by frontline practitioners, coupled with the discretionary authority enacted through their practice, translates the centrally formulated policy into action (Lipsky, 1980, 2010).

The concept of discretionary power is significant for Lipsky (2010), who emphasises that the capacity for practitioner discretion affords a high level of practitioner autonomy. Lipsky's analysis of discretion in street-level bureaucracy focuses on the nature and conditions of street-level bureaucrats' work. Street-level bureaucracies are defined as challenging environments in which to work as the context is characterised by conditions of policy complexity, confusion and resource shortfall (Lipsky 1991). Furthermore, the dynamism of responding to the human dimension of service is recognised as underpinning the capacity for street level bureaucrats to exert discretionary powers. The requirement for street level bureaucrats to exercise professional discretion within the unpredictable context of public service is acknowledged as a prerequisite to responding appropriately to discrete situations and providing bespoke services in response to individual patient need (Evans and Harris 2004).

Paradoxically, Lipsky argues that street-level bureaucrats develop routines and habitual ways of handling these situations, acknowledging that the agency of these bureaucrats is bounded by structural limitations that curtail practice to mechanistic and self-interested approaches to service delivery. As Lipsky reasons

"Ideally, and by training, street-level bureaucrats respond to the individual needs or characteristics of the people they serve or confront. In practice, they must deal with clients on a mass basis, since work requirements prohibit individualised responses.....At best, street level bureaucrats invent benign modes of mass processing that more or less permit them to deal with the public fairly, appropriately and thoughtfully. At worst, they give in to

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences
favouritism, stereotyping, convenience and routinising – all of which serve
their own or agency purposes” (Lipsky 2010 pxiv).

These conditions for practice are created often as a result of fragmented contact with clients and the need to make rapid decisions, typically under conditions of limited time and information. In order for the practitioner to survive in such conditions, Lipsky (2010) suggests that practitioners amend their belief systems and re-adjust their practice; lowering expectations of themselves and the quality of service. As a consequence Lipsky (2010, pp. 179) claims the outcome for patients is adversely affected as the “human needs for nurturing, protection, support, and assistance remain unanswered.” Lipsky (2010) suggests that the attention given to the quality of service has been diluted by the recent focus on quantifiable performance metrics. Neglecting qualitative aspects of service delivery is argued to contribute to the self-fulfilling prophecy of the ineffectiveness and irrelevance of these services as practitioners and managers modify their behaviour to accommodate organisational policy priorities.

However, the discretionary powers of street level bureaucrats, according to Lipsky (2010), has agency in discerning between incompatible or conflicting policies. This is guided by the practitioners’ personal preferences and is directly influenced by organisational objectives to which sanctions (or perceived kudos) are attached. The associated gaming activity (as referenced in section 3.4), enacts street level mechanisms through which street level bureaucrats pursue the preservation of professional discretion and autonomy against the structural limitations imposed by policy mandates and resource paucity. This action formation related mechanism (refer to section 3.12) supports practitioners to make sense of and validate the decisions and work undertaken, closing the gap between their ideal performance and the realities of their street level bureaucratic working context. Although practitioners are castigated for thwarting policy aspirations, the policy distortions implemented by street level bureaucrats are tacitly accepted by managers as pragmatic solutions to invariably vague and unrealistic policy contexts (Lipsky, 1980).

Street level bureaucrats are thus viewed as a policy-making community that exercises discretion in context, wielding political power that can be used in ways that run counter to the patients' or organisational interests. "Public policy is not best understood as made in legislatures or top-floor suites of high ranking officials", but rather it emerges in the "crowded offices and daily encounters of street level workers" (Lipsky, 2010, pp. xiii)

The theoretical debate of top-down versus bottom-up management approaches to the implementation of policy initiatives has been the subject of theorists' enquiry since the 1980s and has featured as a consistent deliberation in central government's welfare reform strategies related to health and social care integration (Schofield 2004). As part of neo-liberal policies, central government has assumed the competitive market as the optimum organisational form, which is premised on practitioners' autonomy to use discretion to achieve optimum results. The competitive market model however fails when the function of an organisation is complex and performance is not easily measured as profit does not hold the same currency within a public service context. A competitive market, real or simulated, is not efficient when collaborative practices between agents are required to exchange information in ways that competition tends to inhibit (Sandfort and Milward 2007). Central government's co-existing classic Weberian bureaucracy approach, governed by formal rules and procedures also has significant limitations in terms of flexibility and responsiveness as the centrally generated and monitored arrangements distance the decision making from the local contexts. This results in strategies that are ill-equipped to adjust to local circumstances (Hayek 1948). Gabel (2012) poses the provocative question as to whether management should strive to eliminate discretion in order to promote the implementation of policies as intended; or should government embrace this bottom-up agency to ensure that policies are adaptive to local circumstance?

Management control and street-level discretion are, in part, an armistice between managers and workers. In considering the inherent problems of managerial control, Lipsky (2010) identifies three factors that shape the street level bureaucrats experience of discretion. The first relates the degree of freedom accorded to the street level bureaucrat by the organisation; practitioners operate within both

observed and unobserved settings that create space for them to act with some autonomy. Moreover, where street level bureaucrats are professionals, their professional expertise is deferred to, relatively free from interference or scrutiny (Lipsky 1980). Organisations will frequently point to the expertise of their members rather than to the success of their endeavours. But once an organisation admits that its members have special skills, it also admits to a limitation of the right to define appropriate street level behaviour (Lipsky 2010). The second identified factor refers to the practical requirement for street level bureaucrats to make their own policy decisions because of a nebulous organisational policy context. Within this milieu, street level bureaucrats make micro street level policy decisions in their interpretation of the ill-defined and/or contradictory practice rules derived from the macro organisational policy context. A self-governing street level directed practice environment is created, impeding the management control of the street level bureaucrat. (Lipsky 2010). Finally, the third dimension relates to the potential for, and the capacity of, street level bureaucrats to subvert policy. The first two factors that construct the space for discretion i.e. degree of freedom and nebulous policy context give street level bureaucrats the latitude to tailor their behaviour to avoid accountability (Lipsky 1980). Street level bureaucrats resist organisational pressures to conform and deliver on the organisational policy aspirations as a defensive mechanism to manage overwhelming work pressures. These conditions create the parameters within which front line practitioners make decisions and act, either to preserve their existing role or to develop their role outwith the confines of the perceived practice constructs (Lipsky 2010). A range of tactics are adopted and these are predicated on exploiting the essentially private nature of their work, influenced by a set of tacit rules and procedures embedded within the pre-existing organisational culture. Autonomous agents are influenced by the social setting in which they operate as the individual's sense of self becomes dependent upon prestige and approval within the organisation, measured against organisational practice norms.

In this sense, conformity to organisational norms and the individual's self-interest are not inconsistent; indeed, on the contrary, the pursuit of self-interest leads to conformity to organisational norms. This implies that the organisational culture will have a stronger hold on decisions the greater the degree to which the agents

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

depend on their colleagues within that organisation for approval and support (Van Maanen 1975, Schein 2004). Howe (1991) criticised Lipsky's position because he sees it as offering support to a mistaken view of professional power in an organisational situation that curtails discretion. He describes the decisive shift in power away from practitioner discretion and towards practice defined by statutes, designed by administrators, and driven by managers. Howe (1991) suggests it is the conditions created by legal frameworks and managerial authority that governs practice and leads to changed situations, not the localised decision and action of front line workers in response to perceived political priorities. Evans and Harris (2004, pp.871) provide a counter argument in their assertions that "the proliferation of rules and regulations should not automatically be equated with greater control over professional discretion; paradoxically, more rules may create more discretion."

Lipsky acknowledges the agency of street level bureaucrats is bounded by structural limitations embedded within organisational rules and regulations, directed and enforced by management, but suggests the relationship between street-level bureaucrats and their managers is one of mutual dependency. The mutuality, trust and reciprocity cited in section 3.6 as key variables in collaborative partnerships between organisations is as pertinent within the collaborative partnership context between practitioner and manager in the operation of discretion (Evans 2006). But for Lipsky this is a 'cold war' reciprocity, based on a recognition of limited power and distrust. Managers are typically motivated to honour practitioner preferences in exchange for rewards by reciprocity in job performance that reflects favourably on their management status. The consequence of not accommodating practitioner preferences is the risk of work practices that discredits management (Lipsky1980). This dependency is further accentuated by the street-level bureaucrat's capacity to exercise discretion and manipulate the nature and flow of information about patients and practice activities. By manipulating the information available, the street-level bureaucrat can limit the manager's ability to influence his/her own behavior resulting in an interference with the organisation's enforcement sequence. As such, managers, in Lipsky's view, are equally inhibited by structural limitations by means of legislative mandates, labour agreements, political opposition etc, but can also be constrained by practitioner solidarity. Interestingly, Lipsky refers to these issues within daily practice of street level bureaucrats as 'dilemmas', not relations of power.

However, Hudson (1993) in his review of Lipsky's theory of discretion makes the connection that Lipsky may in actual fact be referencing an exercise of power relations.

The power exerted by the street level bureaucrat is bound within the levels of discretion accommodated within organisations and is acknowledged as a reason why policy in practice often bears little resemblance to formal public policy. For Lipsky, then, Gabel's (2012) query as to whether management should strive to eliminate discretion in order to promote the implementation of policies as intended is redundant. Lipsky argues managers cannot eliminate discretion. Discretion is an irreducible component of street-level bureaucrats' work; a complex, intricate and integral element of organisational behaviour. All systems of rules or organisational directives require some interpretation and thus discretion. In a classic model of Weberian bureaucracy, the response to the problem posed by interpretation is to clarify the rules and generally to increase their number.

In the period since Lipsky's analysis in the late 1970s, the public sector has undergone substantive reform. The localist rhetoric employed by the early New Labour government and continued through to the current Government has sought to harness the local knowledge of those on the front-line of public services in order to transform the public sector. Yet these reforms have often been contradictory with measures aimed at empowering staff being tempered by centralist intervention and managerialism. As traditional structures become obsolete before new ways of doing things are fully established, the everyday experience for many at the front-line of public services is one of chaos. But there are also opportunities for innovation (Durose 2011). An alternative response within a street level bureaucracy is not to try to eliminate the discretion or to minimise it, but to manage it.

A critique of Lipsky's assertions is the lack of consideration of wider influences from other professional influences within practice situations. Lipsky (2010) focuses on the hierarchical relationship between the practitioner, their line management and the organisation. He fails to acknowledge or consider the potential influence of other professionals within a wider relational structure of the public sector who may direct the interpretation of policy at a street level and shape the nature of the conditions of practice. This would appear to be a short-falling within Lipsky's otherwise helpful

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

proposition regarding the relationship between policy, organisation and professional practice.

3.12. Micro-Macro Mechanisms; Organisational Learning

Morgan (1996) acknowledges that early classical theorists underestimated the significance of social factors on organisational productivity. The prevailing approach to understanding organisations is strongly influenced by historical context and by past and current organisational practice. Locked in this paradigm, the conceptualisation of feasible alternatives is problematic and often obstructs the learning of different ways of working, organising or managing (Brooks 2003). As a result, the same or similar solutions are generated as a response to perceived organisational problems when organisational success is dependent on the organisation's ability to see things in new ways, gain new understandings and produce new patterns of behaviour (Argyris and Schon 1996).

Organisational learning and learning organisations have flourished and have been defined in a wide range of literature (Levitt & March 1988, Cohen & Sproull 1991, Argyris & Schon 1996, Senge 2006). However, the definitions bear some coexisting criticism. First, the concept of organisational learning and learning organisation is "excessively broad, encompassing all concepts related to organisational change in totality. As a consequence, complexities arise from insufficient agreement among those working in the area on its key concepts and problems" (Cohen & Sproull 1991). Secondly, the prevailing concept of organisational learning and learning organisations bear a strong bias towards the traditional scientific approach to management, stressing the supremacy of systems thinking and approaches to organisational continuous improvement (Wang and Ahmed 2002).

Senge's 'system thinking' concept of the learning organisation is an attempt to reconceptualise thinking about organisational learning through a synthesis of systems thinking and learning theories (Senge 2006). Senge (2006) coined five 'disciplines' in his original formulation of the learning organisation: 'systems thinking' (the exploration of wholes rather than individual parts); 'personal mastery' (forms of self-development and individual learning); 'managing mental models' (cognitive models of system change and learning); 'building a shared vision' (creating a

common sense of purpose); and 'team learning' (creating new forms of shared learning and knowledge). The emphasis of 'systemic thinking' with learning based on the fifth discipline "team learning", rather than the other four supporting disciplines, combines systems orientated learning within organisations with concepts of 'communities of learning' based on agential participation. Transformational change within the workplace is posited by Senge (2006) and Caldwell (2011) as being founded on shared learning and participative leadership, as the concept of organisational 'learning' is classified as a strategic activity within the sphere of the organisational leaders' activity.

Paradoxically, the centrality of leaders in Senge's (2006) concept of the learning organisation suggests that learning is dependent on leaders to determine the definition, scope and use of learning, deflating the concept of participative shared learning within the extended workforce. Caldwell's (2005) examination of Senge's systems-based organisational learning concept argues his notion of "distributed leadership" fails to address issues of 'agency' in terms of the extended workforce's expertise and power to act. This effectively undermines the analysis of agency in learning at a micro-individual level; and the collective influence of this in reproducing or transforming actions at a meso-group level and ultimately embedding these at a macro-organisational level (Bourdieu 1977, Giddens 1984). For Senge, the learning organisation is primarily a reconfigured top-down leadership theory of systemic organisational change rather than a theory of agency, change and learning in organisations. The utility of his work is, as a consequence, limited in opening-up new possibilities for understanding the learning capacity at a micro (practitioner) level and the impact of this on the learning potential at both the meso (service) level and ultimately the macro (organisational and inter-organisational) levels.

Argyris and Schon's (1978) pioneering study of organisational learning offers a theoretical construct that redresses the deflation of the agential influence on organisational learning. *Theories of Action* places the human personality as a cognitive psychological mechanism central to learning and goal directed rational action. There are three elements to a theory of action as described by Argyris and Schon (1978). These are

- Governing variables: Those variables that people try to keep within an acceptable range. They include the values, assumptions, theories, beliefs, concepts, rules, attitudes, routines, policies, practices, norms, or skills that underlie people's actions. Any action is likely to impact upon a number of such variables, and so any situation can trigger a trade-off among governing variables as those involved try to keep within their personal boundaries.
- Action strategies: The actions people take to keep their governing variables within the acceptable range.
- Consequences: What happens as a result of an action. These can be both intended (often expressed as goals or objectives) and unintended.

Crucially, Argyris and Schön (1974) distinguish between two contrasting theories of action. An individual's theories of action consist of an agent's "espoused theories" in terms of what they believe they would do in a certain situation; and their "theories-in-use" which refers to their actual behaviour and what they in fact do. This distinction is fundamental in understanding people's actions as they are often governed by theories-in-use of which they are often unaware and this can differ significantly from the values and beliefs to which they aspire and espouse (Argyris 1980).

The distinction between the two theories supports the exploration of whether there is a congruence between the theory in use and the espoused theory. Professional learning requires people to consciously consider what they "say they do and their explanations for their actions" and "what they actually do and the reasons for their actions" (Robinson and Lai 2006:99). Heifetz and Linsky (2004), highlight that the process of addressing any dissonance between an individual's espoused values and their actions or behaviours generates an incongruence that can create a degree of discomfort and result in a sense of loss. However, confronting such incongruence in efforts to reduce the gulf between an espoused theory and a theory-in-use can create the dissonance that supports an individual to learn and develop.

Learning within this context is conceived by Argyris and Schon (1974) as the modification of a theory-in-use which involves resolving areas of conflict between elements of a theory-in-use: governing variables, action strategies, or

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

consequences. The tension within this learning context arises as a result of a person's need to retain their sense of competence by preserving the behavioural world they have created through actions that legitimise their pre-existing theory-in-use. Learning therefore creates a tension between the need to preserve a sense of personal competence and avoid conflict, but as a consequence may give rise to unintended consequences that result in the situation being fundamentally unresolved. Where the consequences of the strategy used are what the person wanted or anticipated, then the theory-in-use is confirmed. This is because there is a congruence between intention and outcome. Where the consequences are unintended, do not match the intended outcome, or work against the person's governing values, Argyris and Schön suggest two responses in the form of single and double-loop learning.

3.12.1. Single-loop and Double-loop Learning

For Argyris and Schön (1978) learning involves the detection and correction of error. Where something goes wrong, it is suggested, an initial port of call for many people is to look for another strategy that will address and work within the governing variables; that is, the chosen goals, values, plans and rules are operationalised rather than questioned. According to Argyris and Schön (1974), this is *single-loop learning*. Single-loop learning is control-oriented and reactive, and leads to corrective action that appears rational: if one action does not work an alternative course of action is followed. The emphasis is on 'techniques and making techniques more efficient' (Usher and Bryant 1989) and is predicated on the assumption that the pre-existing goals, values, frameworks and, to a significant extent, strategies are considered as accurate. This 'theory-in use' model of action is considered as useful by Caldwell (2006) within predictable contexts in which activity is guided by procedural mandates. However, the dangers of this approach in more complex situations is reflected as generating defensive reasoning mindsets, self-deception and counterproductive work routines, which can block access to 'true' rational knowledge and the 'real' causality of effective action and successful learning (Argyris 2004:8).

Brooks (2003), in his quest for the real causality of rational decision making, differentiates between cognitive dissonance and cognitive biases and postulates

that cognitive biases are more prevalent in compromising objective decision making and action. The distortions in thinking within cognitive biases include *illusions of control* (over estimation of an individual's capacity to manage complex problems), *status quo* bias (tendency to keep contexts relatively constant), *bandwagon effect* and *groupthink* (tendency to believe the same things or emulate the practices of others) and *déformation professionnelle* (tendency to limit the perception of things in accordance with the conventions of one's profession). As such, both cognitive dissonance and cognitive biases constrain individual reflective inquiry to single loop learning as the individual's ability to question pre-existing values are thwarted. In contrast, double-loop learning is self-reflective and prescriptive, relatively enduring and rational. It breaks the cycle of single-loop learning by 'the detection and correction of errors where the correction requires changes not only in action strategies but also in the values that govern the theory-in-use' (Argyris 2004).

3.12.2. Theories-in Use: Model I and Model II

Argyris and Schön (1974) posit two models that describe features of theories-in-use that either inhibit or enhance double-loop learning. Model I theories-in-use, synonymous with single loop learning, are shaped by a set of implicit values, centred on a desire to preserve control within a given context, to maximise winning, minimise losing or avoid embarrassment. Model I behaviour is inherently driven by a defensive mindset giving rise to defensive routines' within the organisation. Employees' when confronted with interpersonally threatening situations are driven by face-saving actions that rely on tacit "theories-in-use". These Model I induced behaviours are considered to thwart an individual's or organisation's capacity to examine and modify the values governing actions and to curtail the production of new action strategies that enable learning. An organisation's learning system is interdependent with the theories-in-use that *individuals* 'bring to its behavioural world. Individuals can create and maintain malfunctions within a social system by virtue of their theories-in-use; whilst *social systems* contribute to the reinforcement or restructuring of individual theories-of-use through a web of feedback loops making organisational assumptions and behavioural routines self-reinforcing, inhibiting the 'detection and correction of error'.

Argyris and Schon categorise individuals using Model I single loop strategies as agents who will create Organisational I (O-I) learning systems, characterised by mistrust, 'defensiveness, self-fulfilling prophecies, self-fuelling processes, and escalating error' (Argyris 1982). Ironically, skilled professionals, having acquired academic credentials in one or a number of intellectual disciplines, are schooled to think and reason within the specific paradigm of that profession's teaching. When single loop learning strategies fail, they become defensive, screen out criticism, and deflect the "blame" on anyone and everything but themselves. In short, their ability to learn shuts down precisely at the moment they need it the most (Argyris 1982). The propensity among professionals to behave defensively helps shed light on Argyris and Schon's (1978) observations that government departments have a propensity to generate Model I type single loop learning social systems. Unsurprisingly, Model I predisposed theories-in-use strategies and the associated O-I systems are resistant to change. Organisations can be trapped by previous learning experiences that are retained in the form of routines (Levitt and March 1988). Overreliance on existing routines prevents new solutions from being discovered and stifles innovation and change (Levitt and March 1988). Members of an organisation who place excessive trust in routines are, by and large, unconscious of their own behaviour. Activity is largely governed by practice and social norms manifested through ingrained habits, skills and dispositions without necessarily conscious thought. Bordieus' influential concept of Habitus serves to support the exploration of this ambiguous sociological phenomena as the concept describes a social exchange that occurs within group contexts. Organisations become embodied in agents, structuring an individual's propensity to think, feel and act in determinant ways as the reverberating interplay of agency and structure creates and legitimises socialised norms (Gaventa 2003, Wacquant 2005). In this sense habitus is created and reproduced unconsciously, 'without any deliberate pursuit of coherence without any conscious concentration' (Bourdieu 1984:170).

In Argyris and Schon's (1978) model, strategies to address self-limiting, non-learning systems require a mindset shift whereby individuals think and behave differently by adopting a 'Model II theory-in-use'. Model II theory-in-use exemplifies the double loop learning construct and explicitly draws on and refers to observable data to draw inferences (Argyris 1978). Model II approaches involve extensive

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

inquiry into the views and experiences of others, thereby allowing learning about others' views and minimising defensiveness. Only by examining and modifying the values governing one's actions, is it possible to produce new action strategies that enable learning. When employing Model II, advocacy of views are supported by explanation and an illustration of reasoning processes (Argyris 1982).

Organisational double loop learning is therefore a second order learning, equivalent to what Bateson (1972) refers to as *deuterolearning*. Bateson (1972) distinguished between simple, "proto-learning" and Gestalt learning. Gestalt learning, arguably aligned with Argyris and Schon's double loop learning, refers to the acquisition of insight and apperceptive habits that supports the shift from Model I to Model II theories-in-use through the process of learning to change. Hawkins (1991) and Nielsen (1993) among others, would however contest the status of double loop learning as being synonymous with gestalt learning. Triple-loop learning is contended as being necessary to provide what Hawkins describes as 'the awareness and deeper purpose which contains and informs the strategic thinking and operational realities' (Hawkins 1991, pp.177); and is concerned with change in what Nielsen (1993, pp.118) refers to as the "embedded tradition system" within which the governing values of a behaviour can be nested'. Nielsen suggests (1993, pp.118), that triple loop learning may represent 'a theoretical advance beyond' Argyris and Schön. The concept of triple loop learning is however acknowledged as being relatively ill defined and imprecise. Despite its perceived importance in providing a higher or deeper level of analysis and understanding about organisational learning, there continues to be a lack of clarity and consensus as to how triple loop learning differs from primary and secondary learning forms (Tosey et al 2012). Indeed, although Argyris and Schon did not explicitly refer to triple loop learning in their published work, Tosey et al (2012), Gilmore and Warren 2007, Jakimow (2008) suggest that the scholars inspired the concept of triple loop learning and recognise that these scholars continue to be major influences cited by authors within the field of organisational learning conceptualisations.

Irrespective of the academic debate as to the qualifying attributes of higher level learning to theoretical frameworks, the intent is to reveal the real foundations of defensive organisational routines and develop expert knowledge of the causality of

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

human behaviour. The unveiling of the underlying motives to defensive reasoning, irrational behaviour and political game playing can be made apparent and stimulate the process of learning through cognitive changes and rational action by organisational agents (Caldwell 2011)). The issue is that *individuals* (agents) 'cause' their social systems to malfunction by virtue of their theories-in-use at the micro level, whilst at the same time, *O-I social systems* at the meso and macro levels 'cause' individuals to reason and act as they do. According to Argyris and Schon (1978), double loop learning bridges the status of learning from individual cognition to organisational level learning by revealing irrational individual and group behaviour within the context of organisational learning structures. For organisational learning to occur, 'learning agents', discoveries, inventions, and evaluations must be embedded in organisational memory'. "If it is not encoded in the images or new mental models that individuals have, and the maps they construct with others, then 'the individual will have learned but the organisation will not have done so' (Argyris and Schön 1978, pp. 19).

3.13. Partnership Working: Occupational Therapy in Practice

This section considers the literature within the profession of occupational therapy and positions the profession's relatively unique standing as the only profession employed in significant numbers within health and social care organisations as instrumental in the theoretical exploration of partnership working. This section commences by defining occupational therapy and providing a brief socio-historic context as to the profession's employment within both health and social care authorities. The conceptual values and principles to which occupational therapy affirms its allegiance will then be presented (section 3.13.1). The combination of the socio-historic experience of the profession and the conceptual foundations of the knowledge base converge to create a sense of identity informing the values, attitudes, and practices of a profession. Exploring the identity of occupational therapy in this thesis is important to inform the exploration of the agent, structure interface. Section 3.13.2 explores the profession's current sociological context in the implementation of the standardised MBI and MoHOST assessment and outcome measurement tools. The implications of practice approach within the auspices of the service redesign. Section 3.14. then contextualises the occupational therapy profession's locus within the central government modernisation programme, with a specific emphasis on the Joint Future (2000) agenda. This section encapsulates the

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

theoretical debate regarding the inherent capacity and limitations of the uniquely positioned occupational therapy profession to transcend the health and social care organisational divide to achieve the efficacy aspirations sought by the policy context.

3.13.1. Occupational Therapy Definition and Socio-Historic Summary

The diverse and complex nature of occupational therapy has been noted as contributing to the issue of definition for the profession (Wilding 2010). Nevertheless, the College of Occupational Therapy proposes the following definition to reflect the nature of the profession's *raison d'être*.

“The purpose of occupational therapy is to assist people to fulfil their occupational nature. The main aim of the profession is to maintain or improve the client's functional status and access to opportunities for occupation and participation. The process by which this is achieved is through the maintenance, restoration or creation of a match between the abilities of the person, the demands of her or his occupation and the demands of the environment. Activity is the main medium of intervention and agent of change in occupational therapy”

College of Occupational Therapy (2006, pp. 5)

The Occupational Therapy mode of therapeutic intervention is through the use of meaningful activity (or occupation) to promote and enable individuals to achieve health and wellbeing. Occupations usually have sociocultural meaning and tend to be grouped according to purpose e.g. self-care, leisure, productivity or work (Townsend 2002, Yerxa et al 1989). The engagement of individuals in purposeful activity/occupation promotes participation and establishes an individual's role within society; consequently contributing to the individual's wellbeing through an individual's sense of identity (Creek 2003).

Occupational therapy evolved from the arts and craft movement in the early twentieth century. This movement emphasised the value of creative activity as a therapeutic intervention in the wake of the impact of the Industrial Revolution (Hagedorn 1997). During and after the First World War, casualties amongst young men resulted in an acute shortage of manpower in the workforce. The need to re-

establish these men in open employment facilitated the growth of OT in the treatment of those with physical disabilities (Turner 2002). Curative workshops were opened within military hospitals, based on similar workshops already established in the United States, and were equipped with tools and machinery to exercise joints and muscles. Based on these workshops the first occupational therapy department in Scotland was opened in 1936 at the Astley Ainslie Institution in Edinburgh, where at the same time the first Occupational Therapy Training Centre was opened. The syllabus leading to the Diploma in occupational therapy was primarily underpinned by a medical science body of knowledge, and although the syllabus acknowledged the sociological dimension of patient care in principle, sociological issues were not included in the areas for study (Riley 2002). The reductionist medical orientation was emphasised through occupational therapy activities being prescribed and applied to address diagnostic specific issues (Jones 1964, Macdonald 1970).

The advent of the NHS precipitated the continued expansion and recognition for the profession in terms of both the number of practitioners and professional identity. However, the Government's 1968 green paper on NHS reforms and the Seebohm Report (1968) created consternation for the occupational therapy profession with regard to its future direction. The impending disaggregation of social welfare functions from the health service created a dilemma for the profession. The question related to whether occupational therapists should be located entirely within the NHS or whether a contingent should become part of the new social welfare departments. The profession's main concerns centred on the separation of health and social skills and professional anxieties with regard the perceived threat to the profession's status as a result of being employed within a local authority context (Riley 2002). Specific concerns were expressed that the Seebohm Report undermined the profession's status by assigning a predominantly diversionary remit and not acknowledging the profession's rehabilitative role within the community. There was also anxiety about the possible infringement of the profession's code of conduct, which stated the need for occupational therapy practice to be directed by medical prescription. The Occupational Therapy Professional Association issued a stark statement during this period, reminding occupational therapists applying to work within local authority welfare departments of their responsibilities under the profession's code of conduct. The statement advised that it was 'unprofessional to accept cases except from a

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

medical source' and a medical prescription (referral) was a professional requirement (AOT 1957, pp. 41).

The Association also entered a period of intensive lobbying, advocating that there should be a single occupational therapist with responsibility for service with the hospital and community sectors. The concern was amidst an acknowledgement that the profession was a small, underdeveloped profession which could, as a result of the proposed division into health and social care, sustain collateral damage (AOT 1970a). Notwithstanding these professional reservations, two distinct perspectives emerged among members of the profession which were outlined in a report to the Council of the Association in 1970 (AOT 1970b). The first subscribed to retaining the medical orientation of the profession by advocating that community based occupational therapists should remain employed within the NHS by proposing that community based occupational therapists be attached to general practitioner (GP) within health centres. The second perspective proclaimed an overriding person centred sentiment with the statement 'where ever he (patient) goes we shall go too' (AOT 1970b, pp. 1). The overriding concern was that of patient care and the proposal intimated that occupational therapists should use their skills in consultation with medical and non-medical professional groups to return patients to as full a life as possible within the community.

Despite these early professional theoretical proclamations towards community directed and person centredness practice, the independently commissioned inquiry on occupational therapy, chaired by Louis Blom Cooper in 1989, confirmed that the rhetoric had not been realised in practice. The inquiry did however emulate eminent government strategists, politicians and professional and independent auditing bodies' perspective from the late 1980's in acknowledging that the occupational therapy profession was arguably well positioned to spearhead the partnership working agenda embodied within the prevailing policy directive of the time i.e. Community Care (Stalker et al 1995). The profession's inherent competencies were complicit with the government's strategic aims in that the range of rehabilitative and/or compensatory interventions maintained and/or promoted levels of patient independence; effectively reducing the level of patient dependence on the state to provide support (College of Occupational Therapists 2010). The consensus

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences throughout the following decade was consistent in commending occupational therapy and the equipment and adaptations resource as central to the success of Community Care and the Independent Inquiry reflected the sentiments expressed in its chief recommendation:

“...the profession should prepare itself for a shift away from hospital-based activity towards the assumption of a major role in community care Tomorrow occupational therapists should emerge as major practitioners in community care”
(Blom-Cooper, 1989, pp. 89)

Nearly three decades after Blom Cooper's prediction about the occupational therapy profession emerging as major practitioners in community care, the reality evidences this has not come to fruition (Mountain 2001). Instead of capitalising on the inherent potential of a single profession being employed in significant numbers within both organisations to deliver on the policy objectives, the barriers between health and social care have resulted in their dual employment being perceived as a problem (COT 2002). Occupational therapy is viewed as characterising the “Berlin Wall” divide between health and social care (Dobson 1999, pp. 3). The occupational therapy profession's political immaturity and apparent inability to seize what was deemed a golden opportunity for the profession to rise to the challenge, modernise and transform was swiftly acknowledged by critics within and outwith the profession (Dobson 1999, Mountain 2002). The suggestion is that the profession did not strategise and prioritise the formulation of a plan to respond to the national policy agenda. As a consequence, the opportunity to regroup and unite forces to deliver on the policy context remained unexploited.

3.14. Occupational Therapy and the Joint Future Agenda

The Joint Future Group Report (Scottish Executive 2002), commissioned by Susan Deacon, Minister for Health and Community Care, and chaired by Iain Gray, Deputy Minister for Community Care heralded another “golden opportunity” for the occupational therapy profession to act as a powerful catalyst to reform systems, policies and practices within health and social care (Mountain 2001). The report sought to align existing policy directives with practice examples of innovative projects across Scotland in efforts to share learning and accelerate the response to the integration agenda (Joint Future Group 2000). This policy tactic was amidst

political concern that the efficacies anticipated from partnership working were not being realised and although the strategy retained Modernising Community Care as the cornerstone of partnership working, a range of joint measures were introduced to improve partnership working at the intra and an inter-organisational levels. The Joint Future Group improvement strategy on partnership working continued to pursue public service system efficiencies but incorporated specific measures to engender a person centred ethos that delivered improved service experience and outcomes for the patient.

The Joint Future Group measures to improve partnership working is of particular interest within this thesis on two counts. Firstly, the strategy identifies my profession of occupational therapy as central to the policy initiative and secondly, although not specifically defined as a strategic objective, the Joint Future Group strategy's mechanisms are synonymous with the concept of continuity of care as a driver for change in terms of system and practice developments to deliver organisational efficiencies and improve patient outcomes. The Joint Future Group strategic measures of Single Shared Assessment (SSA), Intensive Care Coordination and Integrated Equipment and Adaptation Services are not articulated in terms that ascribe them to promoting continuity of care specifically. However, the strategy is designed to reaffirm person centred care by modifying professional and organisational parameters of practice and responsibility to realise continuity of care arrangements within and across services. The emphasis is expressed in terms of minimising or removing the incidence of service discontinuity which can arise when patients transition within and between services. Measures to promote effective coordination of information and care at the points of interface between professionals, services and organisations are mandated within this policy context. (Joint Future Group 2000).

The subtleties of obscuring continuity of care as an explicit policy objective can result in insufficient attention being given to the less obvious measurable dimensions therein. As such, the key measures as defined within the strategy were incorporated and operationalised within the research site, under the conceptual continuity of care framework, and became the subject of enquiry and analysis. These included Single Shared Assessment (SSA) infrastructures, inclusive of an

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

inter-organisational information sharing framework; Integrated health and social care occupational therapy services that addressed the incidence of service duplication through intensive care management and the modernisation and integration of the equipment and adaptation service.

The SSA system represents the most transparent and practical application implemented to promote partnership working (Eccles 2008). Its concept was introduced to streamline, coordinate and provide a more structured and personalised exchange between the patient and assessor. The aspiration was to introduce a unified and consistent assessment framework for older people in receipt of health and social care services that promoted person centred approaches within practice. The predicted by product was the realisation of organisational efficiencies created by an anticipated reduction in the incidence of inter-service assessment duplication (Eccles 2008). The role of a lead professional, coordinating and assuming lead responsibility for the single shared assessment was anticipated to become the practice norm, and the outcome of these assessments was envisaged to be accepted by fellow professionals involved with the patient. These single shared assessments were to simultaneously promote a single gateway for patients to access an extended range of health and social care resources. Lead professionals would, within their extended care management responsibilities, be able to directly access a range of health and social care resources on behalf of the patient. (Scottish Executive Health Department 2001b, Modernising Government 1999, Joint Future 2000).

These assessment and care management practice developments were to be supported by system improvements through the creation of a shared patient data documentation set that transcended the organisational constructs and were to be embedded within an integrated information system. The proposed system developments aimed to address the inefficiencies and vulnerabilities arising from the inadequacies in the standard of patient data transfer between services. The multiple data sets and array of non-compatible I.T. infrastructures within health and social care partnerships nationwide, coupled with variable practice documentation standards, are recognised as creating a genuine vulnerability for patients and organisations. The information is typically dispersed in a collection of discrete

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

records, often poorly organised, illegible and not readily retrievable (Eccles 2008). Consequently, managing patient continuity of care effectively is an acknowledged challenge, especially for those patients with chronic and/or multifactorial conditions that are in receipt of multiple services (Coleman, 2003). The Joint Future Group's intent was to emphasise and engender a culture of information sharing that would support single shared assessment practice developments, thus improving the quality of service to the patient through continuity of information that focused on a patient's care journey through their health and social care pathway.

The third strand of the Joint Future Group's offensive was specific measures aimed to modernise the equipment and adaptations service, with a targeted focus on developing the role of the occupational therapy profession. Equipment and adaptations were viewed by the Joint Future Group as being a fundamental component of an integrated community care service. (Joint Future Group Report, 2002). The service was notoriously fragmented with the responsibility of service delivery and management being divided between the NHS, and the local authority social work and housing departments (Joint Future Group Report, 2002). The delineation in role and function was largely directed by legislation and central government guidance on equipment and adaptations (Riley 2002, Boniface et al 2013), all of which pre-dated the Modernising Community Care strategy developments. These legislative and policy influences now served to create barriers to integrated working as organisations struggled to determine which provision should be made under the auspices of health or social care as prescribed within the related government circulars. (Scottish Executive 2003).

The imperative to provide direction and cohesion within this service area was predicated on the intrinsic value of the equipment and adaptations service to support the extended community care agenda. Equipment and adaptations services were viewed as crucial in facilitating hospital discharge whilst reducing or eliminating demands on other health and social care services (Scottish Executive 2003). Equipment and adaptations services were thus deemed a viable strategic part solution to the fiscal challenges being faced as the service's capacity to respond to the government's policy agenda of shifting the balance of care was implicit. Equipment and adaptations services were viewed as crucial in facilitating hospital

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

discharge whilst reducing or eliminating demands on other health and social care services supporting people with wide ranging needs to live within the community setting (Scottish Executive 2003, Audit Commission 2000).

“Equipment for older or disabled people provides the gateway to their independence, dignity and self-esteem. It is central to effective rehabilitation; it improves quality of life; it enhances their life chances through education and employment; and it reduces morbidity at costs that are very low compared to other forms of healthcare. It is no exaggeration to say that these services have the potential to make or break the quality of life of many older or disabled people, and of the 1.7 million people who provide informal care for more than 20 hours a week”

(Audit Commission 2000, pp.6)

Proposals to modernise the equipment and adaptation services were inevitably going to impact on the occupational therapy service structures and practice. Occupational therapists are the only profession employed in significant numbers within both the NHS and Local Authority organisations and were central in the delivery of equipment and adaptations to patients, both within the hospital and community settings (Stalker et al 1995). The centrality of the equipment and adaptations service in community care and the key role occupational therapy services played in the delivery of this resource was unequivocally acknowledged by the government's Joint Future Group. However, the government's strategic vision for occupational therapy was to devolve some of these core responsibilities to create the capacity for the profession to engage in rehabilitative and extended social care. The rationale for this was derived from an emerging international body of evidence that indicated that the occupational therapy profession had the potential to offer wide-reaching cost effective interventions beyond that of equipment and adaptations.

A meta-analysis of the effectiveness of occupational therapy for older persons from an international perspective by Carlson et al (1996) and the systematic review undertaken by Steultjens et al (2005) provided compelling illustrations as to the efficacy of occupational therapy interventions. These positive results transcended the extended health and community care practice context i.e. assessment,

rehabilitation and care management activity, across a range of different diagnostic groups and in respect to a range of preventative, rehabilitative and compensatory occupational therapy interventions. The results are alluring as they report notable dividends in respect to patient outcomes and corresponding fiscal efficiencies within care of the elderly public services. The literature's focus, however, is almost exclusively restricted to the evaluation of occupational therapy interventions within single diagnostic categories e.g. rheumatology, stroke. The efficacy of occupational therapy interventions on the care of the elderly co-morbidity profile is limited. The only notable exceptions are evaluations that appraise projects that target interventions such as falls prevention programmes. These project evaluations were undertaken within a multidisciplinary context and did not evidence the value of occupational therapy specifically. The predominance of occupational therapy service evaluations to within specific diagnostic conditions is not only reflective of the governing reductionist approach to service evaluation, but is also symptomatic of the specialist service specific structural arrangements that contributes to the circumscribed practice perspective on the care of the elderly whose co-morbidities would present with multifactorial symptoms (COT 2002, Ham et al 2010, Cornwell et al 2012).

The Joint Future Group's recommendations specifically called for a redefinition of the occupational therapy profession's role within the integration agenda. The emphasis was on denouncing the organisational demarcations between the health and social care based occupational therapy services which were counterproductive to patient continuity of care. The Group explicitly recommended targeting occupational therapy services more effectively with the objective of achieving full integration of these services by a staged approach. The challenge was to address the cultural and organisational considerations relating to roles, service boundaries, skill sets, professional development, accountability and pay and conditions.

The centrality of occupational therapy and the associated equipment and adaptations service within this strategy created a genuine opportunity for the profession to transform and capitalise on their inter-organisational employment status and embrace the advantage bestowed by the political recognition being afforded the profession. Indeed, the College of Occupational Therapy's publication

Chapter 3. Partnership Working: Legislative Drivers and Policy Influences

in 2002 entitled “From Interface to Integration” responded positively to the reinvigorated policy environment at this time, claiming that for the first time in the UK, the policy’s values were synonymous with that of the profession’s (COT 2002). The significant challenges that integration presented for staff working within organisations engaged in this agenda was however universally recognised (COT 2002, Mountain 2001, Mountain 2002, Cohen 2003). Successful integration and partnership working was considered to be dependent on the profession redressing the persistent “submerged” and “outdated” stereotype as identified by the Independent Commission of Enquiry chaired by Blom Cooper (1989,pp.17).

The College of Occupational Therapy’s modernisation strategy emphasised galvanising the profession’s practice approach, supported by structural change that emphasised continuity of care for patients (COT 2002). The COT strategy recognised the fragmentation of occupational therapy services and attributed the service disconnects to the historic organisational barriers between health and social care. Occupational therapy practice was focused on meeting their respective employing organisation’s operational objectives. Within health services, the role of the occupational therapists was cited as being limited to facilitating hospital discharge as a means to address the hospital bed pressures. The reported consequences on occupational therapy practice was a decline in hospital based rehabilitation as therapists responded to the organisational imperative of meeting the HEAT targets. These pressures for hospital productivity are portrayed as the reason why the profession’s redeployment from the hospital to community based settings was not realised as recommended by Blom-Cooper (1989).

Similarly, the organisational priorities within local authorities were referenced as curbing occupational therapy practice to responding to the statutory duty of equipment and adaptation requests from disabled and older people. The sheer volume of demand for the equipment and adaptation resource, equating to 25-40% of social work referrals was viewed as rendering local authority occupational therapists unable to provide continued therapy or active rehabilitation within the community setting. The local authority’s expectations on the profession was cited as not being supportive of active rehabilitation because this remit was traditionally perceived as the responsibility of the NHS.

As a consequence, the College of Occupational Therapists' report claimed that patients, especially older people, were discharged from hospital with preventable levels of dysfunction and dependence. Furthermore, occupational therapy services, either within the health or local authority context, were portrayed as being grossly under-resourced and powerless to mitigate against this situation. Patients were reportedly deprived of rehabilitative interventions that could promote functional independence. Mountain (2002) disputes the College of Occupational Therapy's perspective that the profession is powerless in mitigating against the organisational limitations to partnership working and illustrates the *agency* of front line occupational therapists. Her conclusions reflect the controlling dynamic of the occupational therapy workforce in determining the direction of service developments in line with Lipsky's concept of street-level bureaucrats and describes this as a perceptible reality. Furthermore, the "cold war" reciprocity denoted by Lipsky was evidenced in Mountain's (2002) findings, as the implications of integration at a practitioner level were demonstrated to undermine the implementation of the strategies irrespective of management buy-in. The occupational therapy profession's behaviour assumed an "ostrich like mentality" (Mountain 2002, pp.44) with an accompanying belief that if the implications of integration were ignored they would disappear. The suggestion is that the intricacies of workforce perception and behaviour should form the basis of developing strategies to affect change. Mountain (2002) concludes by calling for an open debate on the challenge that integration presents at a workforce level in order to dismantle unproductive coercive professional influences.

The ideology presented by the College of Occupational Therapy offers a version of the social reality, and the explanations offered, almost without exception, transpose the practice issues experienced on variables external to the profession. This serves to legitimise current practice and perpetuates single loop, model I learning strategies as described by Argyris and Schon (1978). The consequences of Model I strategies effectively preserve the status quo; a phenomenon that has plagued and has been endured by successive governments seeking to realise partnership working. The central government Joint Future policy context demarcates occupational therapy as the profession of the moment and surreptitiously promotes continuity of care at an informational, management and relational level. This inspired the focus of this

thesis. The key strategic partnership working aspirations of SSA, lead practitioner, integrated IT developments and the modernisation of the occupational therapy and equipment and adaptation service created a context for change. The profession's espoused public proclamation of coterminous doctrines with the policy directive was beguiling as the strategy heralded the potential to realise organisational efficacies, whilst delivering on continuity of patient care. The question is whether occupational therapists (and the profession) are prisoners of the system or whether they are prisoners of their own thinking? And does the current thinking jeopardise the realisation of the "golden opportunity" heralded within the Joint Future policy context, as intimated by Mountain (2002), to become another missed opportunity? Is the profession's preceding experience of not attaining the promising predictions of Blom Cooper's Independent Inquiry in 1989 to be repeated or is the profession indeed uniquely positioned to deliver on the Joint Future partnership working strategy?

Since completion of this study, the introduction of the Public Bodies (Joint Working) (Scotland) Act 2014 (enacted in April 2016) heralds a new era in the in central Government's objectives to realise the aspirations of partnership working. This significant step change by central Government to enforce health and social care integration, was according to Audit Scotland (2015, pp.11), in response to "the relative lack of progress of earlier attempts at integration." The College of Occupational Therapist's response in 2012 to the Government's consultation document, which signalled the intent and scope of the forthcoming legislation, acknowledged the case for change, suggesting a shared recognition that integration from a professional perspective had also not been realised. The professional body welcomed the proposed reforms, but were disappointed that occupational therapy was not specifically identified within the strategy. The College used the consultation opportunity to reaffirm the potential of the profession within the contemporary policy context by stating;

"There is no explicit mention of therapists in this approach and their inclusion would drive the development of preventative and recovery focussed services which enable people to maximise health outcomes and continue to live in their own homes and communities, in line with Scottish Government policies".

The action by the Government to place a statutory duty on the NHS and Councils to integrate health and social care services introduces far reaching reforms in relation to structure, finance and governance; all designed to create opportunities to overcome recognised barriers to change learned from previous experience (Audit Scotland, 2015). Despite the role of the occupational therapy profession not being explicitly referenced within the consultation document, the Scottish Government considers Allied Health Professions, including occupational therapy, as playing a key role in driving change within the Health and Social Care integration agenda. The National Delivery plan for the Allied Health Professions in Scotland (2012), revisits the shifting the balance of care agenda. It charges Allied Health Professions to be more visible and accountable, with a specific reference to being able to demonstrate their impact to the organisation and communities they serve. The document, however, also recognises the considerable paradigm shift and the complexity of the change that continues to challenge the policy aspiration in practice.

Despite the enduring interest in the integration of health and social care occupational therapy services, contemporary literature on the subject remains scarce and the knowledge as to how to facilitate integration remains unclear (Best, 2017). The recent exploratory studies undertaken by Best (2017) and MacGregor (2015) suggest that the profession of occupational therapy continues to be tested by the challenges of integration. Both studies focused on the facilitators and inhibitors to integration as perceived by the occupational therapists engaged in the research studies. The results serve to reaffirm that the structural barriers to change, previously rehearsed, remain e.g. misaligned financial infrastructures, differences in organisational cultures, incompatible IT systems. However, a palpable shift in the participants perception as to what constituted as essential facilitators to integration is noted. Rather than placing an emphasis on the persisting structural constraints, the studies suggest that the occupational therapists stress the supremacy of communication, leadership and joint education as the primary enablers to realising integrated working

The findings within Best (2017) and MacGregor's (2015) studies are aligned to the learning from this thesis. This thesis' conclusions posit that the transformational potential of occupational therapy is indeed influenced by the macro level policy drivers mandated by Government and the meso level implementation of structures ordained at an organisational level. However, it is argued that the mediation of these influences by the occupational therapists as agents of change determines the transformational outcomes (Archer 1995, Lipsky, 2010, Argyris and Schon 1978). As such, strategies to support double loop learning through measures that focus on supporting, galvanising and leading the profession through a sustained programme of change is advocated. Improved communication, innovative leadership and joint learning opportunities, as is promoted by Best (2017) and MacGregor (2015), redirects energies to strategies that develop the profession. This realisation has the potential to transform the profession's future prospects and places the realisation of the policy aspirations within the profession's gift.

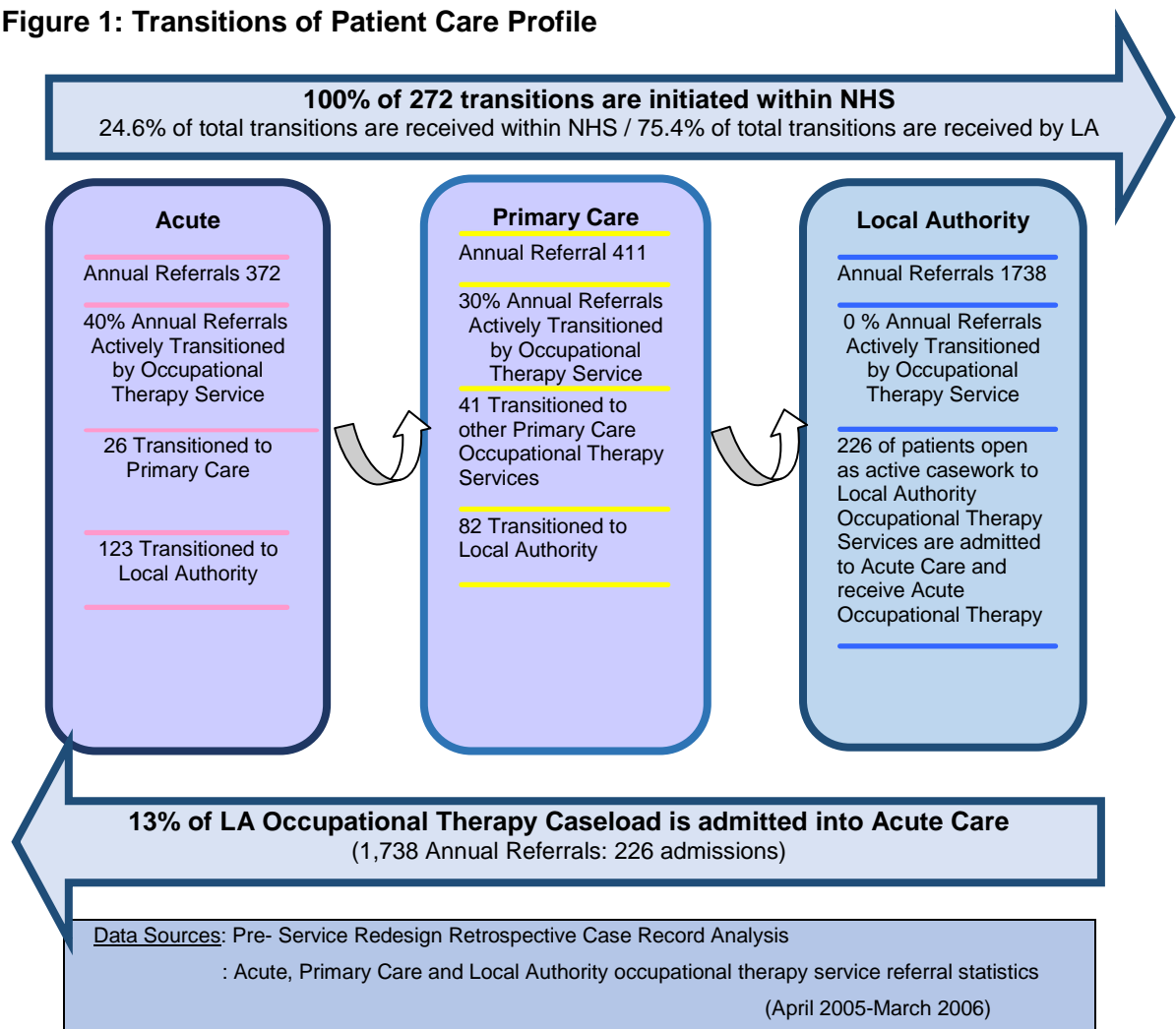
Chapter 4: Transitions of Care - Quantitative Data Analysis

4.1. Introduction

The next three chapters aim to present the results in accordance with the ontological/epistemological critical realist approach whereby the analysis is stratified to achieve mechanistic causal comparability. The focus of this chapter is to present the quantifiable research data that provides a pre and post service redesign occupational therapy service context from which questions as to the potential underlying causal mechanisms can be posed. This exploration aims to further our understanding of the interplay of structure and agent on the redesign outcomes. Chapter 5 will present the qualitative based data, introducing psychological cognitive mechanisms in operation within the service redesign. Chapter 6 further develops the mechanism based theorising approach adopted within this thesis and presents potential explanations with regard to the observed causal tendencies observed within the auspices of the service redesign. The analysis of the relationships are explored by emphasising the synergy and contrasts between the occupational therapists' espoused theories at the empirical level and their theories in action as evidenced at the actual level. The data analysis is cognisant that the analysis of the potential causal explanations can only ever be partial and provisional, as patterns of causal association at the real level are not observable and our understanding is constrained by our assumptions based upon what we know about the world.

4.2. Background: Pre-service Redesign Transitions of Care Profile

The incidence and configuration of transitions of patient care across Acute, Primary Care and Local Authority occupational therapy services as a pre-service redesign measure is represented in figure 1. Figure 1 reflects the number, origin and destination of the transitions of care episodes which arose from the active referrals from one occupational therapy service to another at the time of data collection (retrospective timeframe: March 2005 to April 2006). It also reflects the transitions of care that arose as a consequence of hospital admissions.

Figure 1: Transitions of Patient Care Profile

The patient care pathway across Acute, Primary Care and Local Authority resulted in 498 transitions of care episodes. This equated to 19.8% of the 2521 total service referrals across Acute, Primary Care and Local Authority. 100% of the “active” transitions (272) originated from Health services, which translated into 34.7% (272/783) of all health service referrals being referred onto another occupational therapy service within the system. The additional 226 episodes arose as a result of patients being admitted to hospital. These patients were not actively referred between services, but were “double handled” as although they were known and open to Local Authority occupational therapy staff, Acute occupational therapy staff picked up the patient as a service referral in line with the organisational and practice norms. This was often in ignorance of other occupational therapy service

input, as the absence of a whole system communication infrastructure restricted the transfer of this level of information between services.

Further analysis illustrated that

- Acute services were universal “*initiators*” of active transitions²⁹ of care; though were recipients of *passive* transitions³⁰ of care referrals
- Primary Care were “*initiators*” and “*receivers*” of active transitions of care.
- Local Authority were “*receivers*” of active transitions of care.

The proportion of transitions of care within Acute, Primary Care and Local Authority, relative to their respective annual referral rates was:

Acute:

60.8% of annual referrals to the Acute based occupational therapy service were as a result of passive transitions of care arising from hospital admissions. (226/372).

40% of Acute occupational therapy service annual referrals were actively transitioned to another occupational therapy service (149/372).

7 % of transitions were *initiated* to Primary Care services (26/372).

33% of transitions were *initiated* to Local Authority (123/372).

(*Acute occupational therapy transitioned referral percentages include referrals which were directed to both a Primary Care and Local Authority occupational therapy service simultaneously).

Primary Care:

30% of Primary Care annual referrals were transitioned to other occupational therapy services (123/411).

10% of transitions were *initiated* and *received* within different Primary Care based occupational therapy services³¹ (41/411).

20% of transitions were *initiated* by Primary Care occupational therapy services to Local Authority occupational therapy services (82/411)

²⁹ Active transitions refers to the act of one occupational therapy service actively referring a patient to another occupational therapy service

³⁰ Passive transitions refers to the incidence whereby a patient, already known to one occupational therapy service is picked up as a referral by another occupational therapy service without an active referral being made by the original service.

³¹ Other Primary Care occupational therapy services include Rapid Response Teams

(** ESDT transitioned referral percentages include referrals which were directed to both another Primary Care and Local Authority occupational therapy service simultaneously)

Local Authority:

0% of annual referrals were actively transitioned from Local Authority to other occupational therapy services.

100% of active transitions received by Local Authority occupational therapy services were *received* from NHS Lanarkshire Acute and Primary Care occupational therapy services. (Acute: 123/Primary Care: 82).

These descriptive statistics provide an intra and inter-organisational profile into the incidence and pattern of transitions of care within the respective occupational therapy services. The results illustrate that 20% of all patients in receipt of occupational therapy services experienced transitions of care across services, incurring the involvement of two or more occupational therapists in one care episode.

4.3. Transitions of Care: Service and Practice Implications

Transitions of patient care between occupational therapy services has implications on the patient's experience of care across the occupational therapy care continuum. Table 1 provides an overview of the service profile within the respective services to illustrate the service configuration differentials for patients subject to transitions of care as opposed to patients who are not.

Table 1: Descriptor and Comparator of Transitioned and Non Transitioned Patients

Service	No Transition Length of Stay	Transition Length of Stay	No Transition Number of Contacts	Transition Number of Contacts	No Transition Frequency of contacts	Transitions Frequency of contacts	Transition Wait Time between Services
Acute	27	39	3.8	8.8	7.2	4.4	³² 13 days
Primary Care	15	30	4.2	6.7	4.5	3.7	10 days
%Increase	n/a	↑64.3%	n/a	↑93.8%	n/a	↑30.8%	
Local Authority	129	n/a	2.6	n/a	14.2	n/a	15 days
Total Service	171	198	10.6	18.1	25.9	22.3	25 days
% Increase	n/a	↑15.8%	n/a	↑70.8%	n/a	↑16.1%	n/a

The baseline data illustrated that the patients subject to transitions of care within the occupational therapy care pathway shared an extended length of stay in service. On average these patients remained within service an additional 27 days; equating to an increase of 64.3% within the Health service sector where the increase in the number of days was evidenced. The corresponding whole system increase in length of stay equated to 15.8%³³. The differential in the number of direct occupational therapy contacts with patients being transitioned vis a vis not being transitioned was also significantly higher with transitioned patients within the health sector receiving 93.8% more contacts in an episode of care ³⁴(10.6 to 18.1). The frequency of this contact also increased as the number of days between contacts decreased by 5 days within Acute services and 2.5 days within Primary Care occupational therapy services. The process of transitioning patients between occupational therapy services incurred an inter-service wait period of up to an average of 25 days for the patient³⁵. These wait periods reflected the time between service referral from the

³² Denoting service wait period (in days) for patients transitioned into Acute occupational therapy services as a result of the patient being admitted into hospital rather than actively referred by Primary Care or Local Authority occupational therapy services

³³ Based on the Local Authority length of stay in service remaining constant due to no active transition activity being taken by Local Authority services

³⁴ Episode of care refers to a continuum of patient care that is in response to a primary event until concluded.

³⁵ Wait periods increase to 38 when including the patients transitioned into Acute occupational therapy services that were admitted to hospital and not actively referred by another occupational therapy service. not included within service length of stay

initiating occupational therapy service and service commencement from the receiving occupational therapy service³⁶.

The Local Authority occupational therapy service data did not include patients who were transitioned as the service did not actively transition patients to other occupational therapy services. The service's length of stay data did nevertheless reflect a significantly longer length of stay within service than in Health service counterparts. However, 92 of the 129 days were attributed to parallel processes involved in the provision of service. These 92 days were not dedicated to active occupational therapy service intervention, but were linked to an extended "wait period" for external agencies and contractors supplying the goods i.e. equipment and/or adaptations prescribed by the Local Authority occupational therapist. Within the 36 day *active* length of stay, the average number of contacts was 2.6 and the frequency of contact was every 14.2 days.

In summary a different profile emerges for cases that were transitioned to those that were not. Transition of patient care generated an increase in the length of stay within the occupational therapy service. In addition to the increased length of stay within service, patients who are transitioned accrued extended "wait periods" between services. The evidence also demonstrates that transitioned patients receive more contacts than their non- transitioned counterparts and the frequency of contact increased.

4.4. Occupational Therapy Service Activity: Direct and Indirect Patient Care Activity

The pie charts 1, 2 and 3 represent the respective occupational therapy service activity profiles and are presented in the context of the occupational therapy universal service categories of "assessment", "intervention", "documentation", "meetings", "communication" and "travel". The data was deduced from the time and motion tracking methodology and the unit of measure is time in terms of minutes committed to the service activities. The visual representation illustrates that all three services were dominated by indirect activity. Indirect activity denotes occupational therapy service activity that does not include the direct interface with patients.

³⁶ Wait periods not included within service length of stay

Although there is service specific variation, the percentage of time attributed to direct activity across the whole service system i.e. Acute, Primary Care and Local Authority is 24.8%. This reflects the occupational therapy service activity that includes the direct interface with patients within the service categories of assessment and intervention in their entirety; but also includes the direct component of the communication and meeting categories, where the activity was undertaken directly with a patient within these service activity categories.

Chart 2: Acute Occupational Therapy Service Activity Profile

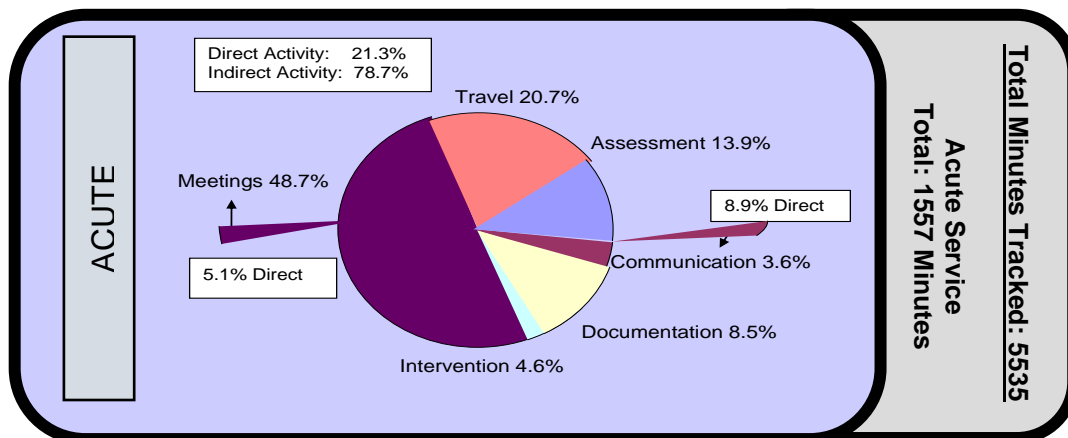


Chart 3: Primary Care Occupational Therapy Service Activity Profile

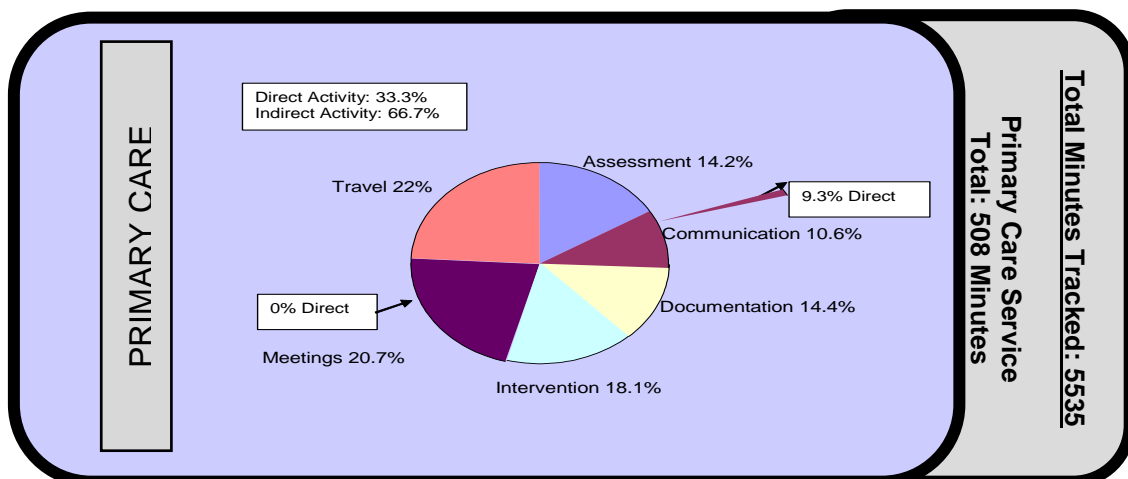
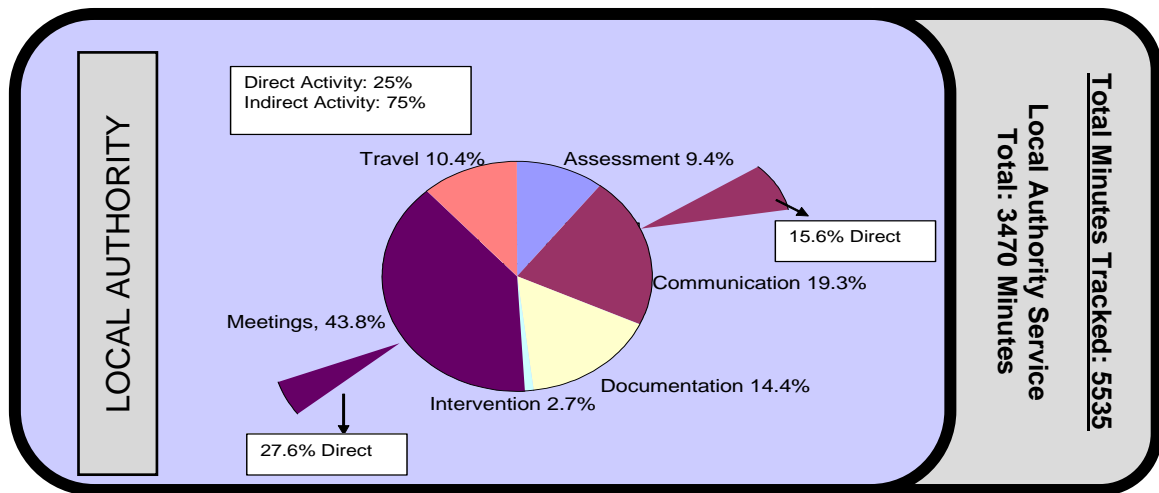


Chart 4: Local Authority Occupational Therapy Service Activity Profile



The direct activity percentage represents the total amount of time frontline occupational therapy practitioner based resources were committed to direct patient service delivery. Occupational therapists accurately estimated this level of direct service activity across health and social care during the mapping workshops. Therapists identified this as a source of great frustration in practice, as they reported routinely feeling pressurised to curtail services to patients, as organisational and service priorities prevailed at all stages in the care pathway e.g. Acute referred to pressures associated with the organisational emphasis for early discharge; Primary Care referred to the 6 week time timeframe and eligibility protocols for service intervention as limited and Local Authority occupational therapy services indicated that the 28 day assessment standard as curtailing.

The 75.2% committed to indirect activity relates to the activities that may be undertaken on behalf of the service user but does not involve their direct involvement. Indirect activities also relate to service activities that are not necessarily undertaken on behalf of specific patients but are undertaken as part fulfilment of service requirements e.g. statistical returns. The categories of documentation and travel were exclusively classified as indirect; whilst the categories of communication and meetings, although predominantly indirect, had a direct component as illustrated within the respective service pie charts.

4.4.1. Direct and Indirect Service Activity: Implications on Continuity of Patient Care

The actual ramifications of the direct and indirect nature of service activities on patient continuity of care is created by actions that occur within and converge to generate the constellation of events at the real level. The data presented within the pie charts 1, 2 and 3, figure 1 and table 1 can only serve to illuminate on activities within these interrelated service categories, developing descriptors and providing comparative data that highlight patterns and associations from which to hypothesise about the relative effect on patient continuity of care.

Tables 2, 3, 4, 5 and 6 reflect the total time commitment to each service activity category by the occupational therapy services across Acute, Primary Care and Local Authority sectors. The tables present this as a percentage of the collective service total tracked time of 5535 minutes. The tables also reflect the proportion of time the respective occupational therapy services commit to each service activity category as a percentage of the service specific tracked time in each category. Each table then presents a summary of the data findings relating to the service category they represent and provides a structure to consider the implications of the results on patient continuity of care at the informational, management and relational levels as a prerequisite to understand their relevance to transitional care.

4.4.2. Direct Service Activity: Assessment, Intervention, Meetings and Communication

Table 2 provides an overview of the direct service activity across Acute, Primary Care and Local Authority services. The direct service activity of 24.8% equates to 1370 minutes of the total Acute, Primary Care and Local Authority service tracked time of 5535 minutes. The direct service activity calculation was configured from the assessment activity (614 minutes), the intervention activity (257 minutes) and the direct communication contact with patients (499 minutes). The direct service activity whereby the occupational therapy service activity directly engages the patient in the process represents the basis for establishing therapeutic relationships that form the foundation for informational, management and relational continuity of care. The nature, purpose, frequency and duration of these service activities establishes the

patient experience of the occupational therapy service and informs the nature of the subsequent service interventions and actions.

Table 2: Direct Service Activity Analysis

Total Activity%	Service Direct Activity Total (Acute, Primary care (PC) & Local Authority (LA))	Total Tracked Time 1370 minutes (499 minutes: Meetings & Communication)
Assessment 11.1% (Acute: 13.9%) (PC: 14.2%) (L.A: 9.4%)	1. Total direct service activity equates to 24.8% (Acute, Primary Care and Local Authority). 2. 81.2% of direct service activity dominated by assessment and communication activity 3. Mode of service assessment included observational (55.7%) and discursive (44.3%). 4. 18.8% of direct service activity directed to intervention 5. 36.6% of intervention was dedicated to therapist's prep time	
Intervention 4.7% (Acute: 4.6%) (PC: 18.1%) (LA: 2.7%)		
Meetings/ Communication 9% (Acute: 0.8%) (PC: 0.09) (LA: 8.2%)		

The prevalence of the assessment activity is shared across Acute, Primary Care and Local Authority occupational therapy. The assessment focus across all service sectors is on activities of daily living (Acute 50.2%, Primary Care 38.1% and Local Authority 51.9%), albeit the method of assessment differs. In Acute and Primary Care services, the method of assessment is principally through observation (76% and 86% respectively), with the balance of the assessment methods being attributed to verbal discussion with the patient to determine the patient's functional status. Conversely, Local Authority service assessments rely predominantly on a discursive dialogue with the patient to determine needs (67.7%) with an observational assessment being the secondary mode of assessment adopted. The different modes of assessment between the services changes the nature and experience of assessment from an objective, clinical analysis of need to one that is a more collaborative approach with patients. The different assessment styles make a distinction between ascertaining the immediate and observable, and gleaning the personal nuances which reflects the individual nature of each patient. There is an

intrinsic value to both methods of assessment in potentially promoting continuity of care at the informational and management levels of continuity of care. The observational approach primarily provides a consistent and coherent approach to the management of a condition that is responsive to a patient's changing needs; whilst the collaborative discursive approach befits the informational continuity of care in using personal circumstances to make current care appropriate for each patient.

The circumscribed incidence of occupational therapy service activity directed to intervention (4.7%, 257/5535 or 18.8%, 257/1370) following assessment to meet the patient assessed need is a provisional interpretation. On further analysis, 94 of the total 257 minutes categorised as intervention time was classified as occupational therapy prep³⁷ time, which would, by definition, not qualify as a direct service activity reducing the service total percentage to 2.9% (163/5535 minutes) and the service specific percentage against the total direct service activity to element to 12.8% (163/1276³⁸ minutes). The services' focus on assessment without adequate service intervention provision may contribute to the pattern of service transitions reflected in Table 1. Current infrastructures and practice norms curtail a longitudinal approach to patient care and thus inhibit continuity of care at the management and relational levels. The data indicates that occupational therapy services within the Health sector were unable to fulfil the interventions required to meet the assessed needs of patients and as a consequence 35% of patients in their care are referred to other occupational therapy services within the care pathway to fulfil the interventions required. The opportunity to form longitudinal therapeutic relations that could remove the need for patient transitions of care between services was not available and occupational therapists were not in a position to bridge the transitioned patient's current and future occupational therapy care.

4.4.3. Indirect Service Activity: Documentation, Meetings, Communication and Travel

Table 3 presents the documentation activity profile of Acute, Primary Care and Local Authority services. Documentation relates predominantly to the informational level of

³⁷ Prep time refers to time taken to prepare in advance of an upcoming event e.g. reviewing patient case history; organising/setting up venue for patient intervention.

³⁸ Direct service total deducted by 94 minutes to reflect non-direct nature of activity

continuity of care. It forms the basis from which patient information on an episode of care within a discrete service can be relayed to future services to promote appropriate patient care when transitioned.

Table 3: Indirect Service Activity Analysis: Documentation

Total Activity%	Service Indirect Activity Total (Acute, Primary care (PC) & Local Authority (LA))	Total Tracked Time 704 minutes
Documentation 12.7% (Acute: 8.5%) (PC: 14.4%) (LA: 14.4%)	1. Mode of service documentation included I.T. (54.1%) and pen and paper (45.9%) 2. 100% of I.T. documentation undertaken within Local Authority services. 3. 36.7% of service documentation related to service progress notes and 31.9% related to assessment documentation. 1.1% of the service documentation related to referring on to another service 4. 24% of the documentation filed in the multidisciplinary team files within the service's organisation 5. 23% of the documentation filed in the occupational therapy service files within the service's organisation 6. 7% was sent to other parallel services (not occupational therapy services)	

The Acute, Primary Care and Local Authority occupational therapy services shared a service focus on documenting the results of the assessment activity undertaken within service and associated progress notes. Each service possessed service specific formats and standards in respect to documentation. This diversity in approach undermined the potential and capacity to share information effectively. The absence of uniformity across the service sectors was emphasised by the method of documentation. Health based Acute and Primary Care occupational therapy services' mode of documentation relied exclusively on paper files; whilst the Local Authority occupational therapy service almost exclusively documented on the organisation's central electronic system. Irrespective of the documentation format, standard or method, all three services retained the documents within their respective employing body's structures. These were either kept within the occupational therapy case files or within the same organisation's multidisciplinary team files. Data sharing across organisational boundaries was the exception and only evidenced within the results to initiate parallel services (not occupational therapy) or as a referral form to another occupational therapy service.

The meeting category within the tracking methodology reflects a range of service related activity that occupational therapy personnel engage in in their daily endeavours. The classification definitions within the Tracker Manual (appendix 1) includes conventional meeting structures within a work environment e.g. Ward rounds, staff briefings and supervision; but also incorporates contracted and non-contracted activities exercised by the staff group within a working day that do not fit the conventional definition of meetings e.g. lunch, coffee breaks and down time.³⁹ The purpose and nature of the meetings defines its utility in terms of patient continuity of care; but as a meeting's primary function is to impart or obtain information, it principally relates to continuity of care at the informational level. Table 4 presents the activity profile in relation to meetings within Acute, Primary Care and Local Authority services.

Table 4: Indirect Service Activity Analysis: Meetings

Total Activity%	Service Indirect Activity Total (Acute, Primary care (PC) & Local Authority (LA))	Total Tracked Time 2385 minutes
Meetings 43% (Acute: 48.7%) (PC: 20.7%) (LA: 43.8%)	1. 66.6% of time within meeting category attributed to non-work related activities. 2. 33.4% of time was dedicated to work related meetings 3. 73 % of the work related meeting purpose was to gather and/or share patient information 4. 27% of the work related meeting purpose was for professional and service direction and development. 5. 78% of the service meeting events did not require further action ⁴⁰ .	

The data reflects that two thirds of the meeting category was engaged on non-work related activities (1588/2385 minutes). This equates to 28.7% of the total minutes tracked for all activities across the occupational therapy services (1588/5535 minutes). From the subset analysis of the meeting category, 82% (1302/1588 minutes) corresponded to contractually based breaks from work activity i.e. Lunch and coffee breaks (591 minutes) and 11 counts of flexi leave (711 minutes). The 18% balance (286 minutes) was associated with breaks from work activity outwith the contractually agreed break periods. Although this quantitative data is not directly

³⁹ Breaks from work activity outwith the contracted lunch and coffee break periods.

⁴⁰ Measurement relates to number of meetings and not time dedicated to the meetings

related to work activities, nor has a direct bearing on patient continuity of care per se, it does provide supplementary contextual evidence about organisational and practice norms that inform the analysis and deliberations in considering the variables that promote and inhibit patient continuity of care and transitions of care.

The activities denoted as work related within the meeting category (33.4%/797 minutes) were confirmed as having the primary purpose of gathering and sharing patient related information (73%). However, 27% of the work related meeting category activities were classified as having the primary function of engaging occupational therapy personnel in professional consultation, support and direction, inclusive of prep⁴¹ time and service development. The data also highlighted that all but 1 of the 218 meeting events tracked within the work related meeting category (797 minutes) were classified as being the original in a sequence, whilst 170 of these meetings were categorised as not requiring further action to address outstanding agenda items specific to the meeting purpose. The high incidence of meetings that are discontinued after a single episode could be interpreted to further validate a hypothesis that current occupational therapy services are by nature transient and as such not conducive to a longitudinal approach to patient care.

Communication is a central tenet to continuity of care at the informational, management and relational levels. Without communication at the informational level, continuity of care cannot be maintained as patients are transitioned between services. At a management level, communication to share assessment data and service intervention care plans is fundamental in achieving management continuity for the patient; and the relational level of continuity of care can only be established and developed through communicative interaction with the patient over time.

Table 5 presents the data within the communication category that reflects the level of active communication between a therapist and other personnel/groups involved in aspects of patient care, and/or the therapist and the patient and/or carer. The communication category represented 14.1% of the total service activity tracked. However, inclusion of the communication activity within the meeting category (with a

⁴¹ Prep time refers to time taken to prepare in advance of an upcoming event (meeting) e.g. supervision

Chapter 4: Transitions of Care - Quantitative Data Analysis

specified intent that could impact on a patient's continuity of care⁴²) augments the total by 317 minutes and increases the service communication percentage to 19.8% (1098/5535). The analysis within this section considers the communication activity denoted in the communication category and represents the data collated within this section only.

Table 5: Indirect Service Activity Analysis: Communication

Total Activity%	Service Indirect Activity Total (Acute, Primary care (PC) & Local Authority (LA))	Total Time Tracked 781 minutes
Communication 14.1% (Acute: 3.6%) (PC: 10.6%) (LA: 19.3%)	<ol style="list-style-type: none"> 41.6% of all communication was in relation to professional liaison 20.3% of the professional liaison communication activity was between occupational therapists 71.1% of all professional liaison communication was intra-organisational 36.5% of communication was directly with the patient or carer. 81% of all communication activity was to obtain or relay information The communication implicit within the meeting category augments the communication tracked data by 40.6% (317 minutes)⁴³ 	

The communication data reflected that 41.6% of all communication was between occupational therapy personnel and other professions (325/781 minutes). Occupational therapy to occupational therapy professional liaison accounted for 20.3% of the professional liaison (66/325 minutes). Direct communication with patients and carers accounted for 36.5% of the total communication activity (285/781 minutes); with patient communication being the most prevalent at 31.6% (247/781 minutes) and carer communication accounting for 4.9% (38/471 minutes) of this communication. 21% of the communication data was categorised as "other"; but the purpose was listed as primarily in relation to obtaining or relaying information. Obtaining and relaying information was, at 81%, the most predominant purpose listed within the communication category total (633/781 minutes). The purpose of communication within the balance of 16.1% (148 minutes) was identified as progress chasing parallel services in 4.3% (34/781 minutes) of the activity;

⁴² Communication activity under the auspices of the meeting category with the specified purpose of gathering/sharing information about patients; about carers or about operational and/or clinical matters

⁴³ Additional minutes not reflected within communication time tracked total.

preparing for communication activity for 10.5% (82/781 minutes) of the time, confirming information in 2.8% (22/781) and 1.3% (10/781) related to referring on activity.

On further analysis of the service communication profile, a number of incongruities present within the data to suggest that current communication patterns within and between services are not conducive to continuity of patient care at the point of transition. The first anomaly is that 71.1% of all professional liaison was on an intra-organisational multidisciplinary team basis. In effect, communication by the occupational therapists within Acute, Primary Care and Local Authority was chiefly confined to within the occupational therapist's employing body. Communication patterns between occupational therapy personnel accounted for 8.5% (66/781 minutes) of the total time dedicated to communication within the communication category (and 20.3% (66/325) of the professional liaison time). Communication between occupational therapists from an inter-organisational perspective accounted for 55.5% (36/66 minutes); whilst 44.5% (30/66) related to communication between occupational therapists from the same organisation.

On examination of the purpose of the occupational therapists' communication, patterns emerged which emphasised that continuity of care at an informational level may not only be compromised by the intra-organisational communication emphasis in practice but also by deed of the occupational therapist's practice itself in obtaining and relaying information. The data suggests that occupational therapists spend 52.6% (184/350 minutes)⁴⁴ of the related time in obtaining information about the patient from other professionals and only spend 19% (67/350 minutes) with the patient or carer on this matter; whilst conversely 64.7% of the occupational therapist's time (183/283⁴⁵ minutes) is spent relaying information to the patient⁴⁶, yet only 5.3%(15/283 minutes) of the time is spent relaying information to professions from within other organisations.

⁴⁴ 350 minutes relates to the proportion of time dedicated to obtaining information as a subset of the 781 minutes within the total of the communication category

⁴⁵ 283 minutes relates to the proportion of time dedicated to relaying information as a subset of the 781 minutes within the total of the communication category

⁴⁶ Total amount of time relaying information to the patient/carers is inclusive of communication during assessment and intervention and does not only apply to communication during transition.

In the context of significant numbers of patients being transitioned between services, the degree to which “accumulated knowledge” of the individual patient is collated and relayed effectively influences the quality of a patient’s transition; yet the information sharing patterns within the documentation, communication and meetings service categories evidenced within the data raises questions as to the prevalence and quality of continuity of care at the informational level.

Table 6 presents the final category to be tracked and represents the ancillary service activity of travel. Travel does not directly relate to patient continuity of care, but the associated data provides contextual information about a service activity that absorbs a significant amount of time, and thus service capacity, within Acute, Primary Care and Local Authority occupational therapy services.

Table 6: Indirect Service Activity Analysis: Travel

Total Activity%	Service Indirect Activity Total (Acute, Primary care (PC) & Local Authority (LA))	Total Time Tracked 794 minutes
Travel 14.3% (Acute: 20.7%) (PC: 22%) (LA: 10.4%)	<ol style="list-style-type: none"> 42.4% of travel time committed to travelling to/from person centred care 56.6% of travel time relates to subsidiary activities. 	

The time committed to travel within Acute, Primary Care and Local Authority occupational therapy services equates to 14.3% (794/5535 minutes) of the total tracked time within the respective services. 45.7% (363/794 minutes) of this time relates to occupational therapists travelling to and from therapeutic sessions either in undertaking an assessment or delivering an occupational therapy intervention e.g. rehabilitation, equipment trials, environmental assessments or home visits. The balance of time (54.3%, 431/794 minutes) is engaged in activities that are not directly related to patient care e.g. preparatory activities for journey or travelling between work bases. The significance of the work travel data is in the distribution and proportionality of time committed to the activity by the respective services. Hospital based occupational therapists within Acute services commit proportionately considerable more time travelling than their community based Local Authority

colleagues; and marginally less time than their community based Primary Care colleagues.

4.5. Service Redesign Measures: Minimising the Incidence of Transitions of Care

The service redesign under study was implemented within the occupational therapy services across NHS Lanarkshire Acute and Primary Care sectors and South Lanarkshire Council Local Authority services. The aim of the service redesign was to minimise the incidence of patient transitions of care through the introduction of practice and system service redesign measures that promoted patient continuity of care at the informational, management and relational levels. This service redesign pilot was completed within the coterminous NHS Hairmyres & South Lanarkshire Council East Kilbride localities between October 2006 and March 2010. The practice and system service redesign measures were incrementally introduced to the research site, with the primary objective of addressing multiple interacting practice and system contextual variables that collectively impacted on each of the services' ability to deliver patient continuity of care.

Four key redesign measures were introduced into the pre-existing organisational structures and systems. These redesign measures were introduced on a discrete service basis with the intent of creating a whole system occupational therapy care approach across Acute, Primary Care and Local Authority services that minimised the incidence of patient transitions of care. The redesign measures aimed to inject practice and system changes within the respective organisational contexts to specifically stimulate mechanisms with the objective of promoting patient continuity of care at an informational, management and relational level as a strategy to minimise transitions of care.

The key primary service redesign measures were the introduction of:

- (1) In-reach and outreach occupational therapy practice arrangements that facilitated patient care beyond the traditional organisational boundaries. Therapists were facilitated to continue to support an allocated patient either into the hospital from the community setting or follow the patient out to the community once discharged from hospital

- (2) A unified evidence based practice approach that transcended the Acute, Primary Care and Local Authority occupational therapy services. This practice approach was embodied and evidenced in the implementation of the Modified Barthel Index⁴⁷ (MBI) and the Model of Human Occupation Screening Tool⁴⁸ (MoHOST)
- (3) A single shared IT system⁴⁹ that facilitated the sharing of information across the occupational therapy services within each of the organisations. The IT solution created an information platform to simultaneously support both the practice and management requirements of the Acute, Primary Care and Local Authority services. Both standardised assessment and outcome measures (MBI and MoHOST) were incorporated within the information system.
- (4) The introduction of a service coordinator to implement a unified approach to the operational management of the occupational therapy services within the research site. This included the provision of practical supports to embed the phased practice and system changes within and between the occupational therapy services; inclusive of direct management responsibilities for the allocation, case management and closure of cases to target practitioners, irrespective of traditional organisational role.

These four discrete service redesign measures were introduced within three distinct organisational contexts; Acute, Primary Care and Local Authority occupational therapy services. The redesign measures were introduced on an incremental basis, as each measure served to create the new context for the introduction of the next measure. Furthermore, the discrete redesign measures themselves generated a

⁴⁷ The MBI is an ordinal scale used to measure performance in a range of activities of daily living and served to reflect the dependency levels of patients in receipt of the respective occupational therapy services.

⁴⁸ The MoHOST is an occupational therapy specific practice applied measurement tool that seeks to explain how occupation is motivated, patterned and performed through a patient's volition, habituation and performance capacity.

⁴⁹ The implementation of the information technology measure could be accommodated within the capacity created from minimising transitions of care. However, an additional organisational financial investment was secured for the procurement of hardware, software and licences

range of sub measures, as the mechanisms activated in response to the primary key measures introduced within the pre-existing context(s) required specific actions (sub measures) to respond to the changing context. Cognisance of the different organisational contexts were acknowledged and the redesign measures were structured to address the distinct and service specific nature of the operational practice and system issues shared across the service sectors; but were also designed to interact in efforts to generate a stratified strategy where the service developments converged to create a whole system change. Similarly, the service redesign analysis acknowledges and reflects the context specific quantitative results arising from the measures introduced, with a sub analysis to explore the potential causal mechanisms at play that gave rise to the preliminary empirical findings.

4.6. Quantitative Data Analysis: Service Redesign Outcomes

The quantitative data analysis adopted a pre and post service redesign analysis approach utilising the research baseline evidence to empirically measure changes in predetermined key performance indicators post service redesign. These indicators reflected specific measures in the patient journey between Acute, Primary Care and Local Authority occupational therapy services that quantified variances in the patient journey profile that may be attributable to the service redesign measures introduced. The emphasis was on reflecting on the outcome of the redesign measures in minimising the incidence of transitions of care through the reduction of the number of occupational therapists in a single episode of patient care across Acute, Primary Care and Local Authority service sectors. Additional quantifiable indicators that illustrated the in service consequences of reducing the number of occupational therapists in efforts to minimise the incidence of transitions of care are also reflected. These were in terms of the patient's average length of stay within service, the average, range and frequency of direct occupational therapy service intervention to the patient, and the service consequences on the assessment/intervention ratio in the delivery of occupational therapy to the patient. The introduction of the MBI standardised patient assessment and outcome measure, under the auspices of the second service redesign measure, facilitated the research capability to quantitatively measure the dependency levels of patients in receipt of occupational therapy services. This data quantified the impact of the occupational therapy service activity on patient dependency levels and provided a profile of patient dependency levels vis

a vis the incidence of patient transitions of care between occupational therapy services.

The pre service redesign data was collated from a cohort of 90 patients (30 Acute, 30 Primary Care and 30 Local Authority), referred to the Acute, Primary Care and Local Authority occupational therapy services. The post service redesign data was derived from the retrospective case record analysis of patients who were subject to the redesigned occupational therapy service. Fifty test cases were identified from a cohort of patients referred to the occupational therapy service across the Acute, Primary Care and Local Authority organisational structures. Of the 50 cases identified, 8 cases were discounted as the medical records could either not be accessed or could not be located at source and a further 3 were also not included as they were designated stroke patients and did not meet the “care of the elderly” criteria. From the remaining 39, 5 cases identified for the Local Authority OT’s were not activated as these cases were deemed as not medically fit within the Acute setting for OT input and either died (n=3) or were transferred to long term care wards (n=2). A further case was subsequently discounted as data fields in the data collection process was incomplete.

4.6.1. Quantitative Data Analysis: Profile of Complete and Incomplete Test Cases and Impact on the Incidence of Transitions of Care

The following results are based on the 33 cases in which the patients were deemed as medically fit for occupational therapy intervention, met the care of the elderly criteria and all or part of the data set could be sourced. Table 7 provides an overview of the performance indicators and the pre and post service redesign measures selected to reflect the key elements of the patient journey through the occupational therapy service sectors. The baseline data presented reflects the whole system position prior to the service redesign. The corresponding post redesign data is illustrated as a whole system data set, but the results are also subdivided and presented to illustrate the results in those in-reach/outreach test cases that were complete i.e. where the primary therapist allocated the case at a point in the patient journey completed the assessment and intervention functions in totality; and those that were incomplete i.e. where the primary therapist allocated the case at a point in the patient journey was not able to complete the assessment

and/or interventions and the patient's care required to be transitioned to another therapist. The complete/incomplete status of the test case profiles are also reflected within the service specific performance measures against each service sector.

Table 7: Care of the Elderly In-reach/Outreach Test Cases (n=33)

Redesign Performance Measures	Baseline Data			Completed test cases			Incomplete test cases**		
Total Number Completed Test Cases	n/a			75.8% (25/33)			24.2% (8/33)		
				<u>Acute</u> 80% (8/10)	<u>P.C.</u> 33% (3/9)	<u>L.A.</u> 100% (14/14)	<u>Acute</u> 20% (2/10)	<u>P.C.</u> 77% (6/9)	<u>L.A.</u> 0% (0/14)
Average Number of Occupational Therapists				1.8					
	2.3			1.5			2.1		
	<u>Acute</u> 2	<u>P.C.</u> 2.4	<u>L.A.</u> 2.4	<u>Acute</u> 1	<u>P.C.</u> 2.1	<u>L.A.</u> 1.4	<u>Acute</u> 2	<u>P.C.</u> 2.2	<u>L.A.</u> n/a
Average Length of Stay (days)	223			179					
	198 ⁵⁰			146			212		
	<u>Acute</u> 39	<u>P.C.</u> 30	<u>L.A.</u> 129	<u>Acute</u> 49	<u>P.C.</u> 127	<u>L.A.</u> 261	<u>Acute</u> 242	<u>P.C.</u> 182	<u>L.A.</u> n/a
Average Direct Contacts	18.5			8.8					
	18.5			8.7			8.9		
	<u>Acute</u> 8.8	<u>P.C.</u> 6.7	<u>L.A.</u> 3	<u>Acute</u> 10.9	<u>P.C.</u> 6.7	<u>L.A.</u> 8.6	<u>Acute</u> 13	<u>P.C.</u> 4.8	<u>L.A.</u> n/a
Direct Contacts Range				1-31					
				1-31			6-20		
				<u>Acute</u> 1-26	<u>P.C.</u> 4-11	<u>L.A.</u> 1-31	<u>Acute</u> 6-20	<u>P.C.</u> 3-7	<u>L.A.</u> n/a
Frequency of Service Contact (days)	8.5			23.2					
				18.2			28.1		
				<u>Acute</u> 5.2	<u>P.C.</u> 19	<u>L.A.</u> 30.3	<u>Acute</u> 18.6	<u>P.C.</u> 37.5	<u>L.A.</u> n/a
Assessment: Intervention Ratio	2:1			(1:4.5)					
				(1:2)			(1:7)		
				<u>Acute</u> 1:2.6	<u>P.C.</u> 1:1.9	<u>L.A.</u> 1:1.5	<u>Acute</u> 1:12	<u>P.C.</u> 1:	<u>L.A.</u> n/a

⁵⁰ Total of 198 days reflecting the need for all 3 services, plus 25 days wait time between services resulting in a total LOS of 223 days

The results reflect a marked difference in the capacity of Acute, Primary Care and Local Authority occupational therapists in undertaking the extended duty of care role as part fulfilment of the second service redesign measure introduced. Primary Care services assumed the extended duty of care responsibility to completion in 33% of cases, whilst Acute and Local Authority services succeeded in 80% and 100% respectively. All eight incomplete cases initiated by Acute and Primary Care services were transferred to Local Authority occupational therapy service for completion. In effect 67% (22/33) of all test cases were finalised by the Local Authority service.

Despite the 24.2% (8/33) of test cases that were not completed successfully, the service redesign appears to have succeeded in realising tangible results in the primary service redesign objective. The number of transitions experienced by the cohort of patients was reduced by 34.7% across the whole system. The average number of occupational therapists involved in the patient's care journey reduced by 26 therapists (75-49) across Acute (8), Primary Care (3) and Local Authority (15). This resulted in the average number of occupational therapists engaged in the patient's care reducing from of 2.3 to 1.8 therapists across both complete and incomplete test cases. However, the reduction in the number of occupational therapists that minimised patient transition experiences was reserved to the complete test cases and the percentage reduction as part of the completed test cases cohort equates 44.8% (58-32), the average number of therapists involved in a patient's care journey reducing from 2.3 to 1.5 across the Acute, Primary Care and Local Authority occupational therapy services.

The most significant level of reduction (19/26) was evidenced when the combined effects of the IT, unified management arrangement and the inreach/outreach redesign measures were realised. The introduction of the IT service redesign measure provided the coordinator with a patient tracking facility that provided the service intelligence to facilitate the management action of removing dual referrals to multiple occupational therapy services at source. This, combined with the occupational therapist's capacity to assume the extended duty of care role beyond the traditional practice parameters, effectively removed the role of a therapist within the care pathway at source and subsequently removed the need to transition the patient to another therapist. The balance in the reduced number of therapists (7/26)

arose exclusively as a result of management actions that removed duplicate referrals to multiple services within the system. The occupational therapy practice within this group remained within the auspices of the pre-redesign practice norms as therapists provided interventions within their respective organisational structures and in accordance with their traditional roles. The proposition is that the reduction in the number of therapists within the complete test cases was effective and the suggestion is that it is possible for patients to have their needs met by fewer occupational therapists in a single care episode.

The incomplete test cases also evidenced a reduction in the number of occupational therapists engaged in a patient's care pathway. The number of therapists reduces from 2.3 to 2.1. The post redesign analysis of the data does not provide an adequate explanation for this apparent reduction, as the incomplete test case data did not reflect any reduction in the number of therapists within the incomplete test cohort (17-17). Speculation as to the reasons underpinning this reduction evidenced within the incomplete cases relate to confounding variables arising from undetermined potential differences in, for example, the patient cohorts or changes in the behaviours within the occupational therapy treatment group that were not causally related to the specific service redesign measures introduced; albeit the measures may have acted as a catalyst to affect contextual changes at the empirical, actual and/or real levels that facilitated undetected changes in the workforce behaviour patterns before and during the pre and post-test measures. Notwithstanding this research design and analysis limitation, the results are still noteworthy in reflecting a whole system reduction in the number of transitions for patients under the care of the redesigned occupational therapy services.

4.6.2. Quantitative Data Analysis: Outcome on Patient Length of Stay in Service Pre and Post Service Redesign

The effect of this redesigned service arrangement on patient length of stay within the respective occupational therapy services is reflected within Table 7 and illustrates a whole system patient length of stay in service decrease of 19.7% (223-179 days). The baseline data reflects the pre redesign service arrangements whereby patients could be transitioned through each of the service areas in sequential order from the Acute phase to the Primary Care and then to the Local

Authority occupational therapy services. The length of stay was therefore calculated as a cumulative total of three distinct services (198 days), with an additional 25 days incorporated (223) to reflect the average “wait period” patients experienced between the points of patients being discharged by the original referring occupational therapy service to being activated by the receiving occupational therapy service.

Within the complete test cases, the data indicates that each discrete occupational therapy service experienced an increase in the patient length of stay when compared to the services’ respective baseline results. However, the extended care needs of patients within the complete test cases were met by a single service, and as a result, the whole system patient length of stay reduced by 34.5% (223 days to 146 days). This reduction within the complete test cases includes the 25 day “wait” period experienced by patients who were referred to multiple occupational therapy services within the traditional service model. The variation in the patient length of stay within services, ranging from 49 days in Acute, 127 in Primary Care and 261 in Local Authority is intriguing. This is considered within the patient dependency profile data analysis in section 4.7 which suggests an inter-service differential exists in terms of patient complexity and service activity. The incomplete test case data also portrays a 4.9% whole system decrease in the patient length of stay within service. This decrease in in-service length of stay is calculated on the basis of the combined days a patient was under the care of both the original occupational therapy service (which was unable to meet the needs of the patient) and the receiving service, which finalised the occupational service intervention within the patient’s single episode of care. Despite the incomplete test cases requiring to be transitioned to Local Authority occupational therapy services, the length of stay is accredited to the original service within the inreach/outreach exercise. From this perspective, the Acute occupational therapy service’s increase in the patient length of stay was 363.9% and Primary Care’s increase equated to 43.3%.

4.6.3. Quantitative Data Analysis: Range, Frequency and Nature of Occupational Therapy Service Contact Pre and Post Service Redesign

On reviewing the direct contact data, including the range and frequency of service contact, a number of observations emerge. The first is in respect to the 53.5% (18.5 to 8.6 contacts) reduction in the number of contacts patients receive within both the

successfully and unsuccessfully completed test cases across the occupational therapy care pathway. As previously indicated (length of stay data), the baseline data reflects the pre redesign service arrangements whereby patients could be transitioned through each of the service areas in sequential order from the Acute phase to the Primary Care and then to the Local Authority occupational therapy services. The direct contact was therefore calculated as a composite total of three distinct services (18.5 contacts). The number of direct contacts within the complete test cases is represented as an average of the three services as the patient experience within the complete test cases is denoted within the primary service providing the care. Within the complete test cases, the results reflect that the impact of the in-reach/outreach service redesign measure on the patient direct contact variable varied across the discrete occupational therapy services. Acute and Local Authority occupational therapy services both increased their direct patient service contact to 10.9 and 8.6 contacts respectfully. The primary care occupational therapy service's direct patient contact remained constant (6.7 contacts) to the baseline position within the successfully completed test cases undertaken within their service. Similarly, the range of contacts delivered within the completed test cases also reflects a synergy between Acute and Local Authority services' results, with the range being 1-26 within Acute and Local Authority being 1-31. Primary Care services again deviates from the pattern by reflecting a more limited range of between 4 and 11.

The data in respect to the frequency of service contact reflects that Acute occupational therapy services have retained the frequency of direct service contact within the test cases that were completed (every 5.2 days) by maintaining a relatively high incidence of contact within a relatively short length of patient stay in service timescale. This presentation changes significantly within the incomplete test cases, as although the direct contact level actually increases, the patient's extended length of stay reduces the frequency in which the contact is provided to 18.6 days. The Primary Care and Local Authority services, which have traditionally operated within the community setting, demonstrate a direct contact frequency level that is much less than the traditionally hospital based Acute service counterparts. Each share notably less direct contacts with the patient with markedly increased patient lengths of stay within service. Notwithstanding this, a significant disparity exists even

between these two traditionally community based services in respect to the frequency of contact within complete test cases. The Primary Care frequency of contact is every 19 days, whilst the Local Authority service average is every 30.3 days. The Primary Care incomplete test case data set illustrates that the frequency rose from 19 days within the complete test cases to an average of once every 37.5 days.

The recalibration of the assessment/intervention ratio from the baseline result of 2:1 to a whole system assessment/intervention ratio of 1:4.5 is a positive shift. The presupposition is that the occupational therapy services have refocused service interventions to more fully address the identified needs of patients within their care, as opposed to the core service function being that of assessment. However, further analysis on the nature of the direct contact within the redesigned service evidences that 100% of the direct contacts removed within the test cases relate to assessments. In effect, this redress in removing the duplicate assessments within the occupational therapy care pathway, coupled with the increase in service contacts within Acute and Local Authority services, collectively contributed to the recalibrated assessment: intervention ratio.

The rebalancing of the service focus on interventions potentially positions occupational therapists to more effectively manage the service support to a patient by delivering improvements in continuity of care at a management level. The service's pre-redesign emphasis on assessment created a whole system occupational therapy service arrangement that had arguably little value to the patient. In effect patients were subjected to repeat reassessment as they were channelled through multiple organisational systems with predetermined criteria and timeframes, with little capacity to implement rehabilitative or remedial interventions that responded to patient need. However, the sub analysis between the complete and incomplete test cases (complete 1:2 / incomplete 1:6.6) again illustrates a stark differential and challenges any assumptions as to the actual value of increasing the intervention element of services without a fuller understanding of the qualitative benefits realised in patient care. The results indicate that patients within the incomplete test case cohort received over 3 times more interventions than the patients within the complete cohort. Nevertheless, these patients were transitioned

to other occupational therapy services for the intervention to be finalised, as the identified needs could not be accommodated within the original allocated occupational therapy service.

In summary, preliminary empirical indicators imply that the service redesign measures introduced within the occupational therapy services had the potential to reconfigure existing service arrangements within resource to adopt a whole system, longitudinal approach to patient care that responds to the continuity of care agenda at the informational, management and relational levels. The I.T. and unified management approach created the service capability to direct and target the whole system occupational therapy resource, avoiding unnecessary and duplicate activity within the patient pathway experience; whilst the in-reach/outreach practice arrangement promoted the capacity for occupational therapy services to develop a longitudinal approach in the management of patient care that engendered therapeutic relationships based on accumulated information and knowledge of the patient and their circumstances.

The service redesign's success in reducing the number of occupational therapists engaged within a single episode of patient care across the Acute, Primary Care and Local Authority occupational therapy services achieved its objective in minimising the incidence of transitions of patient care. The test case results, however, illustrated that the success rate of the in-reach/outreach service redesign measure was not universally achieved across the occupational therapy service sectors. Differences arose within the Acute, Primary Care and Local Authority occupational therapy service's capacity to assume the extended duty of patient care. Patterns emerged from the complete and incomplete status of the in-reach/outreach test cases, demonstrating both service symmetries and inconsistencies in terms of the subsidiary measures of patient length of stay, average number of occupational therapists involved, frequency and range of direct contacts and associated variances in the assessment: intervention ratio. The results suggest underlying service context diversity that generates differences in how each service enacted the redesign measures resulting in the documented service variation. The service specific completed test case data suggests significant differences in practice across the three occupational therapy services and questions the value of reducing the

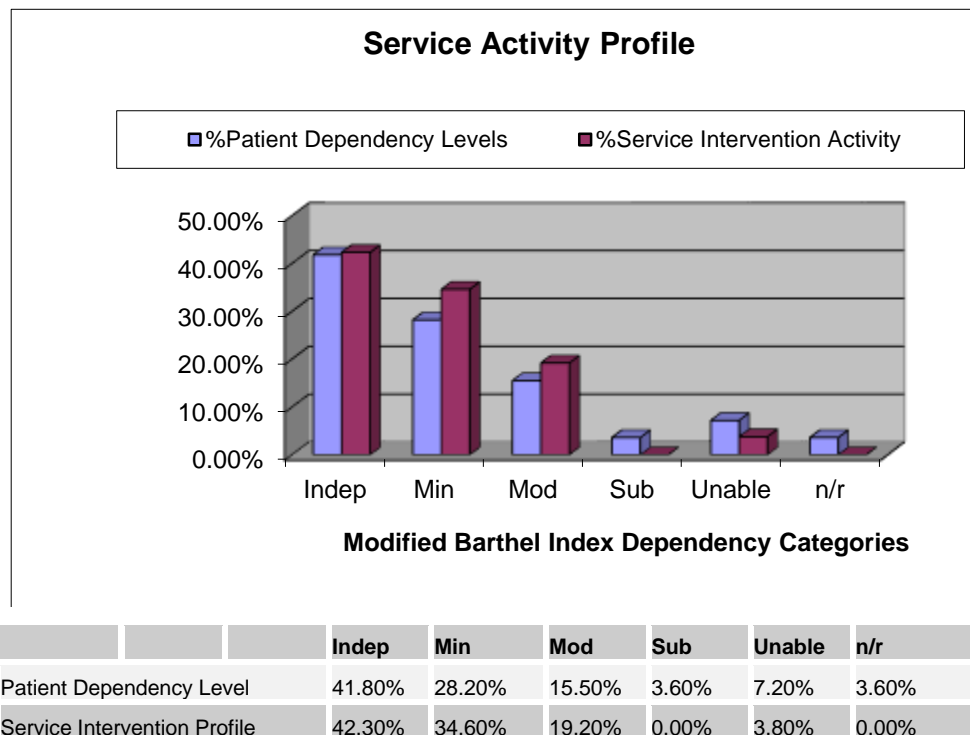
incidence of patient transitions in achieving improvements in patient continuity of care. This, in conjunction with the divergent incomplete test case data, effectively presents contradictory evidence to challenge assumptions about specific performance measure results that could be interpreted to indicate improved patient continuity of care. For example, the extended length of stay in service, a measure associated with the potential to positively affect relational continuity of care, is almost five times greater in the Acute incomplete test cases in comparison to the average length of stay within the complete test cases. Equally, the direct contact percentage decrease of 52.4% across the whole system would seemingly contradict the person centred service development hypothesis and appears to undermine the concept of relational and management continuity of care as the direct contact with patients is significantly reduced. This, combined with the variation in the patient length of stay within discrete service areas, presents an irregular and contradictory pattern of practice that infers that services may continue to be directed by variables other than patient continuity of care.

4.7. Quantitative Data Analysis: Exploration of Observed Service Variances across Acute, Primary Care and Local Authority Occupational Therapy Services

In establishing such variation between services as outlined in Table 7, further exploration of the nature of service activity sought to provide an insight as to what may contribute to the differences between the Acute, Primary Care and Local Authority occupational therapy services.

Graphs 1, 2 and 3 depict the dependency levels of patients in receipt of the respective services and illustrates the discrete service's corresponding resource investment in providing interventions in respect to the cohorts of patients with different dependency categories as determined by the Modified Barthel Index measure.

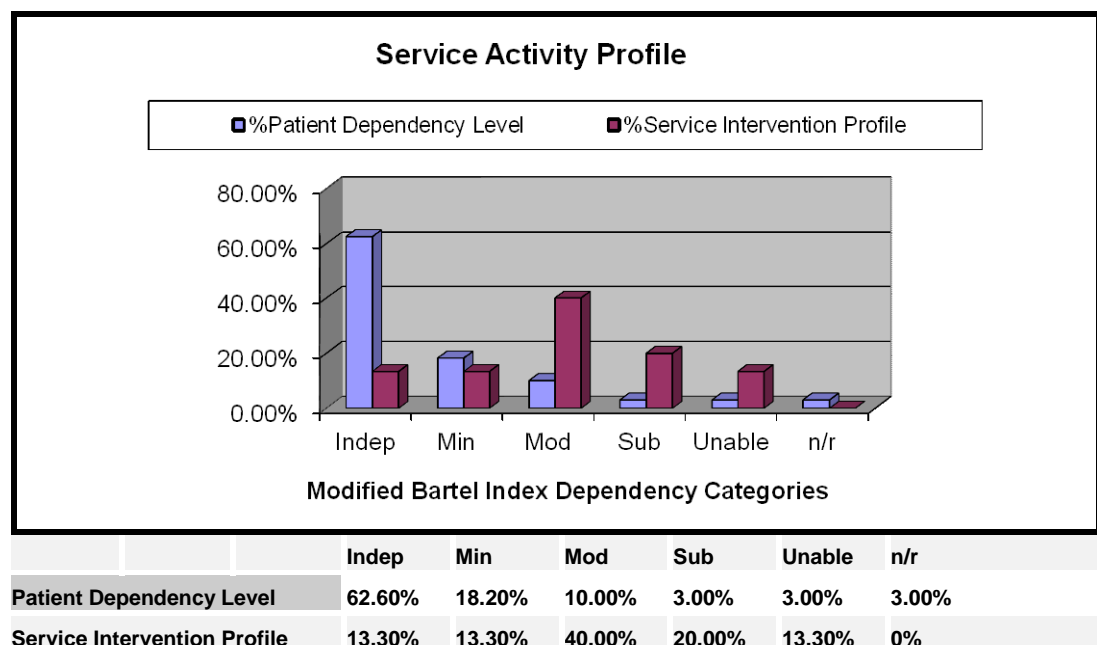
Graph 1: Acute Occupational Therapy Services: Patient Dependency Levels and Service Intervention Activity Profile. (n=10)



The profile of patients in receipt of Acute occupational therapy services do not have significant levels of dependency, with 70% having dependencies rated within the independent to minimum dependency categories. This patient population received 77% (20/26) of all Acute occupational therapy interventions. The patient cohorts who were deemed as independent at assessment (41.8%) received 42.3% (11) of the interventions; 9 of these interventions related to transfers practice and/or provision of related equipment, whilst 2 were in relation to kitchen rehabilitation. This is despite these patients having no identified dependencies. Unsurprisingly, these patients did not improve their functional independence in these areas. Indeed, 2 of the patients declined to engage in the interventions. Questions are therefore raised as to the rationale for this apparent inappropriate resource investment. Is there a therapeutic purpose in these interventions e.g. maintenance of patient ability pending discharge; or are services configured to provide set interventions irrespective of identified need? Patients with moderate, substantial and unable dependencies collectively represented 26% of the dependencies identified. These dependency levels would have significant ramifications in the patients' abilities to

function within these areas. 77% of this patient cohort was reliant on formal or informal carers for support in these specific activities of daily living. The 6 (23%) service interventions dedicated to this level of dependency appears to be woefully inadequate, and again, the rationale for what appears to be a disproportionate distribution of resources is questioned. Is the nature of the identified dependencies not appropriate for occupational therapy intervention or, as indicated in the incomplete data sets, are Acute occupational therapy services not constructed to intervene in these types of dependencies and why do they require to be transferred to Local Authority occupational therapy services for completion?

Graph 2: Primary Care Occupational Therapy Services: Patient Dependency Levels and Service Intervention Activity Profile. (n=9)

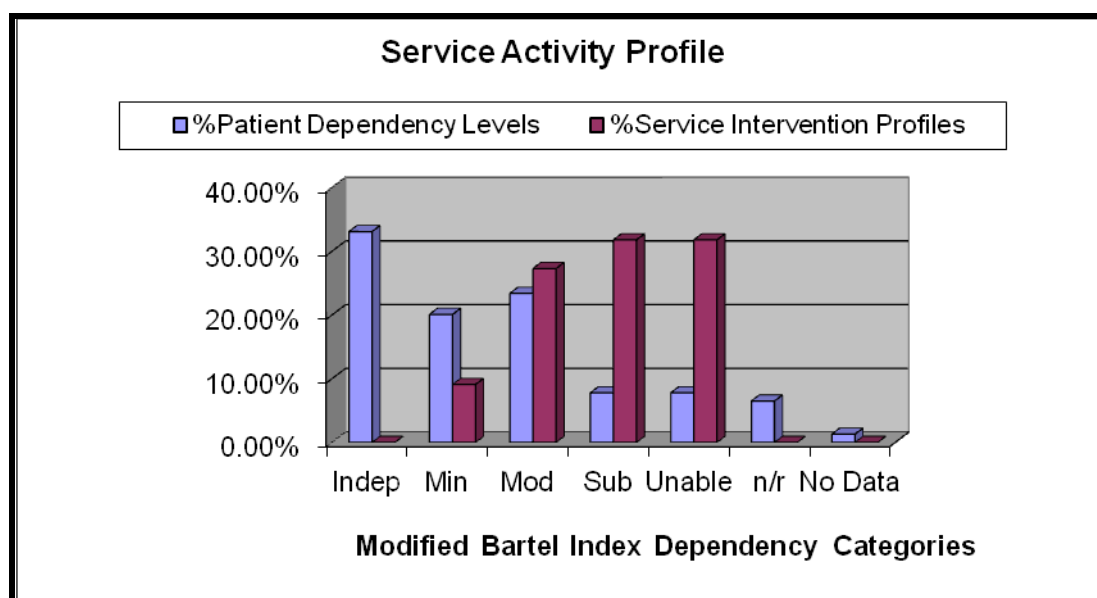


The Primary Care occupational therapy service patient profile reflected in graph 2 suggests a remarkably low level of dependency, with 80% of the patients categorised as independent or as having minimum levels of dependency. Although proportionately a significantly lower level of service intervention capacity is dedicated to those patients who have no identified dependencies (26.6% (4/15)), the recorded outcomes of these interventions are similar to that of the Acute service i.e. no improvements in patient functional ability. 73% of the intervention capacity (11/15) is directed to the 16% that represent patients with dependency levels in the moderate, substantial and unable categories. This appears to be a more

Chapter 4: Transitions of Care - Quantitative Data Analysis

proportionate distribution of resource capacity as resources are directed in line with areas of most significant need. However, the number of incomplete test cases within this cohort of patients (67%) indicates that despite this distribution of resource capacity, the effect on patient continuity of care is undermined as patients are again transitioned to the Local Authority occupational therapy service for completion.

Graph 3: Local Authority Occupational Therapy Services: Patient Dependency Levels and Service Intervention Activity Profile. (n=14)



	Indep	Min	Mod	Sub	Unable	n/r	No Data
Patient Dependency Levels	33.10%	20.10%	23.40%	7.80%	7.80%	6.50%	1.30%
Service Intervention Profile	0%	13.60%	22.70%	31.80%	31.80%	0%	0%

The dependency profile of the patient cohort within the Local Authority occupational therapy service illustrates that the patient population is independent or has minimal levels of dependency in 53.2% activities assessed, whilst the patients with moderate, substantial and unable dependency levels represent 39% of the patients in receipt of the service. The majority (91% (20)) of this service intervention capacity (22) is dedicated to these 39% of patients, whilst the 13.6% (3) balance is directed to those with minimum dependencies. Two further points of departure exist within this patient service intervention profile in comparison to the Acute and Primary Care occupational therapy services. The first relates to the fact that no intervention capacity is directed to those patients assessed as being independent, whilst the

second relates to the level of capacity invested (63.6%) in the 15.6% of patients within the substantial and unable categories of dependencies.

4.7.1. Quantitative Data Analysis: Patient Dependency Profiles and Acute, Primary Care and Local Authority Occupational Therapy Service Activity

The variations in respect to the patient dependency profiles are marked between the three discrete services, but perhaps even more noteworthy is the individual service's investment of the resource capacity to the patient with varying levels of dependency. The Acute service intervention emphasis on patients who are independent or have minimum levels of dependencies (77%) is not reflected within the Primary Care service (26.6%) and appears to be in extreme contrast to the practice within the Local Authority service (13.6%)

These stark service demarcations in the delivery of patient care begin to suggest a considerable inter service variation that has not been addressed through a practice and system redesign. Despite significant investment and espoused *buy in* by the respective service personnel and organisations, variables within the discrete occupational therapy services clearly have supremacy in preserving the defined role of the occupational therapist within service and curtailing practice to historic practice norms. This creates a significant challenge and is a fundamental barrier to realising a whole system approach that promotes continuity of patient care across the Acute, Primary Care and Local Authority occupational therapy care continuum.

Tables 8, 9 and 10 explore the degree of the inter service variations in patient care and provide an overview of the interventions provided by the respective occupational therapy services against the activities of daily living (ADL) measured within the Modified Barthel Index. These interventions are listed denoting whether they were prescribed through a reported assessment format or whether the assessment engaged the occupational therapist in the more labour intensive approach of patient observation at the assessment stage. This distinction was instigated to decipher whether the discrete service emphasis was predetermined and whether the service specific contextual variables directed the occupational therapy activity, irrespective of the aspirations of the service redesign, or indeed, the needs of the patient.

Tables 8, 9 and 10 also present data that reflects the outcomes for patients in terms of improvements on their functional abilities within specific activities of daily living following the interventions provided by the respective occupational therapy services.

Table 8: Acute ADL Service Activity and Patient Outcome Profile

	Acute Occupational Therapy Services							
n=10	Assessment/Need/Intervention/Outcome Profile							
ADL	Reported	ID Need	Intervention	Outcome	Observed	ID Need	Intervention	Outcome
Personal Hygiene	100%	60%	0%	0%	0%	0%	0%	0%
Bath	80%	80%	10%	0%	20%	20%	10%	10%
Feeding	100%	0%	0%	0%	0%	0%	0%	0%
Toilet	10%	10%	0%	0%	90%	30%	80%	20%
Stairs	80%	70%	10%	10%	20%	20%	10%	0%
Dress	70%	60%	10%	0%	30%	20%	10%	10%
Bowel	100%	30%	0%	0%	0%	0%	0%	0%
Bladder	100%	30%	0%	0%	0%	0%	0%	0%
Mobility	0%	0%	0%	0%	100%	90%	20%	0%
Transfers	0%	0%	0%	0%	100%	50%	70%	30%
TOTAL	64%	*34%	3%	1%	36%	*23%	20%	7%
(n=10)								

*Balance of 43% with ID Needs relates to ADL activities assessed as independent.

3 interventions not cited in MBI related table relate to kitchen activity

The focus of the Acute occupational therapy observed assessment was clearly on mobility and transfers (including toilet transfers), with 81% of the observed assessments being within these activities of daily living. Similarly, a high percentage of the service interventions (74%(17/23)), irrespective of whether they arose from the observed or reported categories, were related to mobility, transfer and toilet activities, albeit the interventions related to mobility were significantly less at 12% (2/17). This service assessment and intervention emphasis on transfer related activity is further borne out on reflecting that 9⁵¹ of the 23 service interventions responded to patients who were assessed as being independent in the transfer activities they received interventions for.

⁵¹ 2 further interventions directed at patients assessed as independent were in relation to kitchen activity that is not subject to MBI measurement – resulting in the total of 11

Table 9: Primary Care ADL Service Activity and Patient Outcome Profile.

n=9	Primary Care Occupational Therapy Service							
	Assessment/Need/Intervention/Outcome Profile							
ADL	Reported	ID Need	Intervention	Outcome	Observed	ID Need	Intervention	Outcome
PH	100%	44%	0%	0%	0%	0%	0%	0%
Bath	67%	44%	33%	11%	33%	33%	33%	11%
Feeding	100%	0%	0%	0%	0%	0%	0%	0%
Toilet	0%	0%	0%	0%	100%	11%	0%	0%
Stairs	22%	11%	0%	0%	78%	55%	55%	0%
Dress	100%	44%	11%	0%	0%	0%	0%	0%
Bowel	100%	11%	0%	0%	0%	0%	0%	0%
Bladder	100%	22%	0%	0%	0%	0%	0%	0%
Mobility	0%	0%	0%	0%	100%	44%	11%	0%
Transfers	0%	0%	0%	0%	100%	44%	11%	11%
TOTAL	59%	*18%	4%	1%	41%	*19%	11%	2%

*Balance of 63% with ID Needs relates to ADL activities assessed as independent

15% intervention rate on 37% id need level=59.4% assessed unaddressed need

NB 3 in receipt of intervention with no outcome data

2 interventions not cited in MBI related table relate to kitchen activity

The Primary Care occupational therapy service assessment and intervention activity similarly generates a pattern to suggest a predetermined service framework that largely directs service activity to key component activities of daily living. The emphasis placed on mobility and transfers (inclusive of toilet transfers) is a focus shared by the Primary Care occupational therapy service with their Acute service counterparts. However, the data reflects that the community based service focus is extended to include the mobility related area of stairs and the self-care area of bathing as service priorities for intervention. Observational assessments, however, continue to be reserved primarily to the mobility and transfer related activities.

Table 10: Local Authority ADL Service Activity and Patient Outcome Profile

	Local Authority Occupational Therapy Service								
(n=14)	Assessment/Need/Intervention/Outcome Profile								(n=19)
ADL	Reported	ID Need	Intervention	Outcome	Observed	ID Need	Intervention	Outcome 1	Outcome 2
PH	100%	43%	0%	0%	0%	0%	0%	0%	0%
Bath	64%	64%	36%	7%	36%	36%	21%	21%	41%
Feeding	93%	14%	0%	0%	7%	7%	7%	7%	7%
Toilet	57%	29%	14%	7%	43%	21%	14%	0%	13%
Stairs	57%	57%	14%	0%	43%	43%	29%	21%	27%
Dress	100%	79%	0%	0%	0%	0%	0%	0%	0%
Bowel	100%	21%	0%	0%	0%	0%	0%	0%	0%
Bladder	100%	43%	0%	0%	0%	0%	0%	0%	0%
Mobility	21%	14%	0%	0%	79%	86%	0%	0%	0%
Transfers	14%	7%	0%	0%	86%	57%	7%	0%	0%
TOTAL	71%	*37%	6%	1%	29%	*25%	8%	5%	9%

* Balance of 38% with ID Needs relates to ADL activities assessed as independent

NB 6 in receipt of intervention with no outcome data

1 intervention not cited in MBI related table relate to kitchen activity

The Local Authority occupational therapy service assessment and intervention profile, like Acute and Primary Care, evidences activity patterns that suggest a predetermined service framework from which service activity is governed. The emphasis on specific activities of daily living is mirrored with Primary Care service counterparts in that the interventions target identified dependencies in the mobility and transfer related activities, including toilet and stairs, and the personal care activity of bathing. The Local Authority service profile illustrates that the reported mode of assessment is more pronounced than in the Acute and Primary Care services, with 71% of assessments being undertaken in this manner. This included elements of the mobility and transfer related activities that Acute and Primary Care reserved solely for the observed assessment category.

4.7.2. Quantitative Data Analysis: Acute, Primary Care and Local Authority Occupational Therapy Service Intervention and Patient Dependency Outcomes

On reviewing the intervention data vis a vis the identified need data, patterns begin to emerge to reflect that the correlation between areas of assessed dependencies are not universally synonymous with the interventions. With the Acute occupational therapy service, 42.3% (11/26) of the service interventions were directed to patients

assessed as independent in the activity of daily living areas intervened with. The balance of 15 service interventions (57.7%) was directed to patients within the minimum (9), moderate (5) and unable categories (1). However, 72.5% of patient identified need did not receive any interventions to address the areas of dependency, (deducting 6% for the bowel and bladder categories where occupational therapy has limited scope for intervention). Interventions were almost 7 times more likely if they were identified within the observed assessment category, supporting the impression that the occupational therapy service assessment and intervention activity is largely predetermined and is service driven, as opposed to driven by patient need.

The impact of the interventions provided within the Acute service, (as reflected in Table 8 (23%)), on recorded patient outcomes was reduced as a consequence of the emphasis of service intervention on patients within the independent category with no significant potential for improvement. The 11 interventions relating to independent categories resulted in no improvements. The 23% investment in addressing assessed dependencies through occupational therapy interventions resulted in an 8% return on patient outcomes. Unsurprisingly, 80% of this return was registered within the observed assessment category.

On reviewing the Primary Care service intervention profile, service intervention activity appears to be targeted to where a level of dependency has been assessed, (other than the 2 interventions directed to activities of daily living in patients assessed as independent (outlined in Graph II). The Primary Care intervention activity also appears to be more widespread and encompasses a greater number of activities of daily living. However, similar trends exist, though to a lesser extent than the Acute occupational therapy service, in that the incidence of interventions where the assessed need was observed is almost 3 times more likely to receive an intervention when compared to the reported assessment intervention rate. Furthermore, 59.4% of assessed need, whether observed or reported, remains unaddressed (deducting bladder and bowel categories where occupational therapy has limited scope for intervention)

21% of intervention activity was directed to those patients with minimum dependencies, 43% directed to moderate dependencies, and 14.5% to patients with substantial or unable levels of dependencies respectively. The impact of these interventions on improving patient's functional abilities within the range of dependency levels were evidenced to be between 33% (1/3) within the minimum dependency category to 50% (3/6) in the moderate, substantial (1/2) and unable (1/2). However, all but one (unable) of these patient improvement outcomes were as a result of Local Authority interventions when they were transitioned to complete the intervention and as a result are not reflected within Table III as an outcome. As a consequence the 15% investment in interventions resulted in a 2% return in patient outcomes.

The Local Authority occupational therapy service profile suggests 43% of the service interventions were directed to those patients with a reported need (Acute: 13%, Primary Care: 27%). The level of assessed unmet need within the Local Authority service cohort is 73.1% (deducting bladder and bowel categories where occupational therapy has limited scope for intervention), a figure comparable with their Acute sector colleagues (72.5); both of which are significantly more than their Primary service colleagues whose assessed unmet dependency level stands at 59.4%.

The distribution of Local Authority occupational therapy service interventions presented as 5% of intervention activity being directed to those patients with minimum dependencies, 25% directed to moderate dependencies, 30% to patients with substantial and 35% to patients within the unable category of dependency. The impact of these interventions on improving patient's functional abilities within the range of dependency levels, inclusive of those patients transitioned to Local Authority services, were evidenced to be 50%(1/2) within the minimum dependency category to 75% (6/8) in the moderate, (100%) within the substantial dependency category (7/7) and 14% unable (1/7). One patient improved without any occupational therapy intervention. In effect, 14% of Local Authority occupational therapy service investment resulted in 10% patient functional improvement outcomes.

4.7.3. Quantitative Data Analysis: Patient Assessed Needs and Occupational Therapy Service Interventions.

The Modified Barthel Index (MBI) pre-intervention scores reflected a total of 204 assessed needs across the patient cohort in receipt of Acute, Primary Care and Local Authority occupational therapy services. The majority of these identified needs relate to activities of daily living that fall within the auspices of the occupational therapy profession's license to practice, and as such, were within the profession's professional license to address as part of a therapeutic programme of intervention. The only exceptions are the categories of "bladder" and "bowel" as occupational therapy intervention would arguably have limited impact on any identified dependencies within these areas. The 19 dependencies identified within these categories more readily relate to medical considerations rather than functional limitations. As such, for the purposes of the analysis within this research the 19 dependencies within these categories have been deducted from the total of 204, leaving 185 assessed needs where occupational therapy should and/or could intervene.

The empirical data analysis highlighted significant omissions in the incidence of occupational therapy service interventions and illustrated specific trends and anomalies that suggest that occupational therapy practice was directed by influences other than person centred care. The occupational therapy services' combined number of therapeutic interventions totaled 63 episodes of care (Acute (26), Primary Care (15) and Local Authority (22)). Of these, 13 interventions (Acute (11), Primary Care (2)) were directed to patients with no assessed need, resulting in the incidence of interventions being directed to assessed need being 50 out of a possible total of 185 (27%). Effectively 73% of the patients' assessed needs relevant to occupational therapy were not addressed by the profession within Acute, Primary Care or Local Authority. Intriguingly, the need identified in the "personal care" category was conspicuous in being the only activity (other than bowel and bladder management) that did not incur any level of intervention from the services. This was despite 19 of the 33 patients registering a level of dependency ranging from minimum to unable (57.6%). On further analysis, service specific trends emerge that reflect the discrete service foci on specific activities of daily living. Within Acute services, the occupational therapy service activity focused on transfers, toileting and

kitchen activities (69.2%/18/26). Acute occupational therapy services were the most prolific in providing intervention where no assessed need was identified. 42.3% (11/26) of this service activity was delivered to patients with MBI pre-intervention ratings of "independent". The Primary Care service's emphasis centred on bathing and stairs (73.3% / 11/15), with 1 of the 2 interventions relating to an activity being undertaken where the patient was assessed as independent (bathing). The focus of Local Authority intervention activity was on bathing, toileting and stairs (81.8%/18/22). All interventions undertaken had an identified level of patient need.

These results present an inter-organisational occupational therapy service that appears to be both significantly circumscribed, and at times, ostensibly misdirected. These apparent service limitations raise questions as to the impact and value of the service to patients and certainly challenge the perception that services are person centred. Conversely, the MBI post intervention measurement results do indicate that where occupational therapy delivered an intervention that addressed an assessed level of need, 50% (25/50) of the patients registered an improvement in their levels of independence (Acute 53.3% (8/15), Primary Care 23.1.% (3/13) and Local Authority 63.6% (14/22). Table 11 provides a synopsis of the occupational therapy service provision activity inter-organisationally. This is presented in terms of equipment and adaptations and rehabilitative interventions. It also presents an indicative measure of the outcome of each on patient dependency levels.

Table 11: Inter-Organisational Service Intervention and Outcome Profile

Acute, Primary Care & Local Authority Occupational Therapy Services									
Equipment & Adaptation (E&A) & Rehab Intervention (Rx)/Outcome Profile									
N=33									
ADL	E&A	Rehab	E&A & Rehab Total	Intervention to Assessed Dependency	Rx: Assessed Dependency (E&A)	Improvement Outcome (E&A)	Rx: Assessed Dependency (Rehab)	Improvement Outcome (Rehab)	Unrelated Improvement Outcome
PH	0	0	0	0	-	-	-	-	1
Bath	15	0	15	15	15	10	0	0	0
Feeding	1	0	1	1	1	1	0	0	0
Toilet	8	4	12	7	7	4	0	0	2
Stairs	12	0	12	11	11	3	0	0	3
Dress	2	1	3	3	2	1	1	0	2
Bowel	-	-	-	-	-	-	-	-	-
Bladder	-	-	-	-	-	-	-	-	-
Mobility	1	2	3	3	1	0	2	0	4
Transfers	3	7	10	6	3	2	3	3	3
Kitchen	3	4	7	4	1	1	3	0	0
TOTAL	45	18	63	50	41	22	9	3	15
					E&A Improvement Outcome 53.7%		Rehab Improvement Outcome 33.3%		

However, attributing these increased levels of independence exclusively to occupational therapy intervention would be tenuous as the data also reflected a further 15 patients (excluding bladder/bowel categories) with improved levels of independence where occupational therapy did not provide a service. There does, however, appear to be an increased incidence of patient independence levels improving within specific MBI categories when patients are in receipt of occupational therapy intervention. These include bathing, with a ratio of 8:1, toileting 4:1, transfers 5:3 and stairs 4:3. Furthermore, the results within the MBI categories related to feeding only reflects a singular incident of improvement where occupational therapy intervention is provided. Contrariwise, all 4 registered improvements in the levels of patient independence within the mobility category were not in receipt of occupational therapy; whilst those in receipt of occupational therapy services within the mobility category did not improve their level of independence. Similarly, the category of dressing reflected a higher ratio of patient improvement in the absence of occupational therapy intervention with a ratio of 2:1.

An improvement in a patient's level of independence was likewise noted in the personal care category, despite no occupational therapy intervention.

4.8. Quantitative Data Analysis: Concluding Reflections

In conclusion, this service redesign aimed to affect system and practice change with the introduction of four key measures into three discrete occupational therapy services that represented the whole system patient care pathway through Acute, Primary Care and Local Authority organisations. The emphasis was to realise patient continuity of care at an informational, management and relational level.

The empirical analysis of data suggests that the aspiration to achieve improvements in patient continuity of care was, on a superficial level, successful in that 73.5% of in reach/outreach test cases were completed. The corresponding service indicators in relation to the patient's increased length of stay within service and an increase in frequency of contact with a post service redesign emphasis on intervention as opposed to the pre redesign focus on multiple assessment, all create an inclination that patient's care at an informational, management and relational level should have improved. The potential to engender more productive therapeutic relationships in practice arguably had the capacity to generate a service context that promoted patient trust (relational continuity of care). This, in itself, could manifest as increased levels of patient confidence in the therapist, providing an opportunity to glean information that would not routinely be available in the pre redesign service arrangements constrained in terms of time and contact. This longitudinal collation of patient information serves to contribute to continuity of care at an informational level. The patient flow of information would not be artificially interrupted by service cessation and had an inherent value at a management continuity of care level, in serving to inform and improve the quality of the service interventions being provided by the occupational therapy service. The personal aspirations of the patient and their expectations of what the service could support them with, combined with the occupational therapist's depth of knowledge about the patient's capacities and potential, creates a different premise from which services could be constructed and delivered. This continuity and depth of information, predicated on fewer occupational therapists being involved in the patient's care journey, is enhanced as it removes the

need to transfer information between occupational therapy services where patient data can be miscommunicated, misinterpreted or lost.

However, the empirical data also highlighted significant intra service variations in terms of ability and/or capacity to assume an extended duty of care role within the auspices of the in-reach/outreach measure, which raised questions as to the service specific contexts that generated these differentials. This, combined with the unanticipated service activity profiles, which reflected compelling disparity between services in relation to patient dependency profiles, and incongruent associated service intervention activity that appears to be primarily service driven, rebukes the conceptual ideology in reality. The empirical evidence presents the occupational therapy services as being clearly constrained in realising the patient continuity of care aspiration. As a result, questions arise as to not only the validity of the initial interpretation of the success of the service redesign in achieving person centred continuity of care improvements, but also as to why this has occurred.

The imperative is to further explore and analyse the potential underlying mechanisms that give rise to these empirical findings in efforts to understand the interplay of variables that both enhance and constrain the realisation of patient continuity of care within one professional discipline employed across the two public services of NHS Lanarkshire and South Lanarkshire Council. The question is, to what extent occupational therapists in their altered structural context are empowered to assume the extended role and consider patient continuity of care as a determinant in influencing the nature and duration of the service interventions vis a vis the pull of the traditional organisational and professional influences governed by service criteria, predetermined timescales and practice norms?

Chapter 5: Service Redesign -The Agency of Occupational Therapists

5.1. Introduction

This chapter aims to explore the mechanisms that result in the observable tendencies reflected within chapter 4. The aim here is to explore the potential underlying mechanisms, and the activation of these, through the occupational therapists' agency. As such, the emphasis is on exploring the agency of the occupational therapists operating within their pre-existing service structures, whilst responding to the structures introduced through the service redesign measures. Through eliciting the occupational therapists' espoused perspective on their experience of the service redesign, and analysing this in the context of the empirical evidence, inferences can be conceptualised as to the potential generative causal explanations as to the service redesign outcomes.

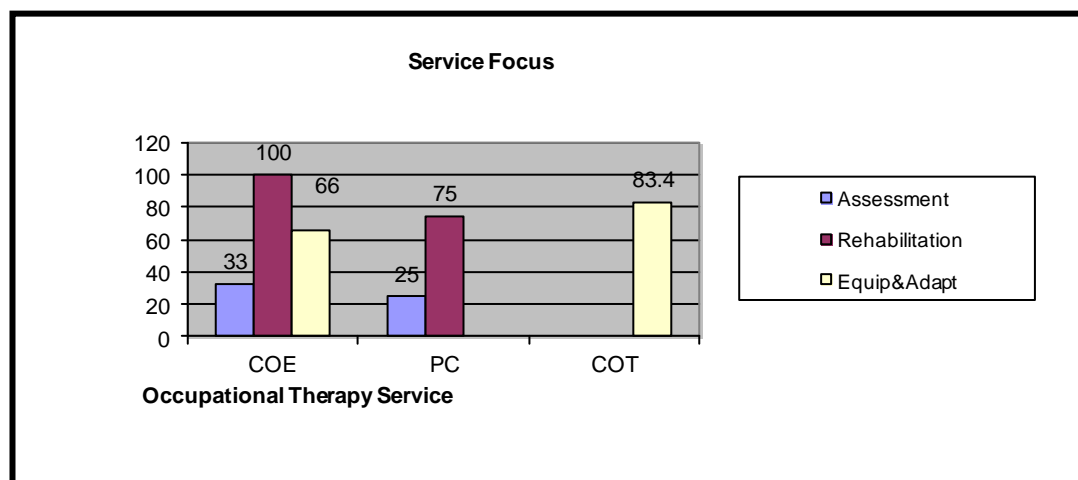
5.2. Occupational Therapy Services: Perceptions of Service Redesign Measures

The views and perceptions of occupational therapists engaged in the service redesign were elicited via a single semi-structured interview. The semi structured interview format engaged therapists in a taped discursive dialogue about their perceptions of the current service focus, service drivers, professional role and service outcomes. The second element of the semi structured interview format structured the dialogue to their personal experience of the service redesign measures; namely, the inter-service, evidence based practice approach, the centralised management arrangements, the IT infrastructure and the introduction of the in-reach/outreach practices. The responses provided an insight into the mindsets of the occupational therapy staff group and provided a contextual framework to explore and hypothesise on the behaviours of the therapists and the potential relationships with the service redesign outcomes within the 3 discrete services. 13 occupational therapists were interviewed: 3 therapists from the NHS Acute Care of the Elderly Service (including a service manager with responsibility for the occupational therapy service within both the Acute and Primary Care services within the research site), 4 NHS Primary Care occupational therapists and 6 Local Authority Occupational Therapists (inclusive of a service manager with responsibility for the research site Local Authority occupational therapy service).

5.2.1. Occupational Therapy Services: Perceived Service Focus and Professional Role

Occupational therapists from Acute, Primary Care and Local Authority services universally articulated their respective service's focus and primary role therein with conviction. Graphs 4 and 5 provide a synopsis of the therapists' espoused perceptions and views in respect to the current service focus and respective professional role in the context of their employing body.

Graph 4: Reported Occupational Therapy Service Focus

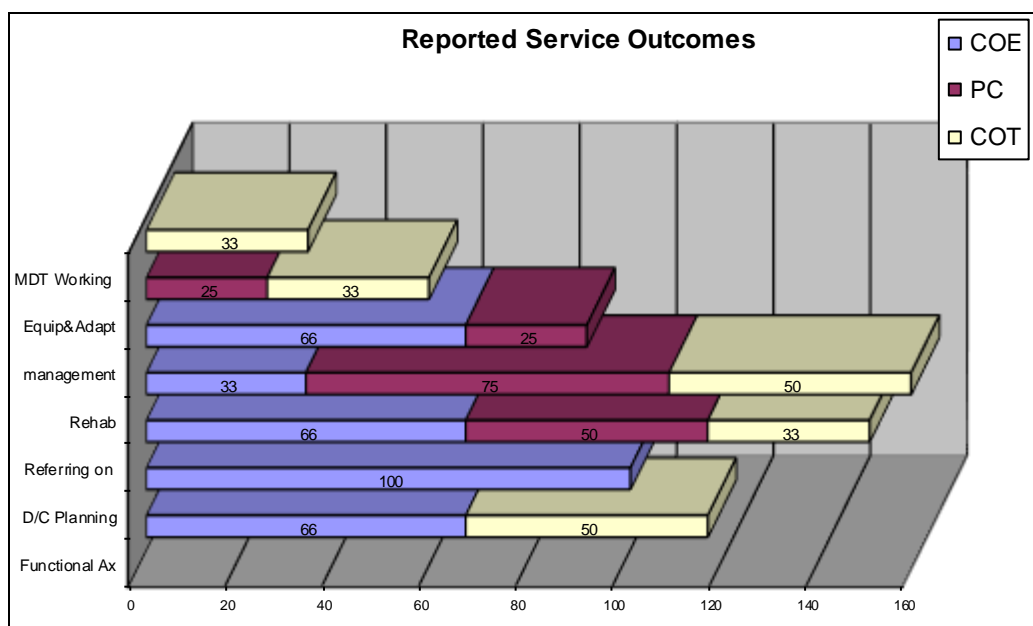


The services demonstrated some synergy as to the perceived service focus in identifying the core functions of “assessment”, “rehabilitation”, and “equipment and adaptations”. These functions were again denoted as a primary professional role in service, but were augmented with the remits of “referring on to other services” and “management”. The identification of these shared functions, as either a service focus or as a professional role, by the respective services begins to illustrate some consensus as to the role and purpose of occupational therapy across the Acute, Primary Care and Local Authority service sectors.

However, the variation in emphasis and value placed on each function across the discrete services (as outlined in Graph 5) begins to highlight some of the underlying differences in practice. Additional service specific reported primary roles of “discharge planning” and “multidisciplinary working” (MDT) accentuates some of these differences, reflecting the therapists' espoused intent to fulfill their employing

Chapter 5: Service Redesign -The Agency of Occupational Therapists organisation's discrete operational priorities. An apparent disconnect begins to emerge across the three service sectors between what the therapists perceived as the service focus within their respective employing organisational context and the therapists' espoused perception as to their professional role in practice.

Graph 5: Reported Occupational Therapy Service Primary Roles



Irrespective of the perceived service focus or perceived professional role, the actual prevalence of equipment and adaptations as a service intervention was evidenced within the empirical data as being 81.5% of all occupational therapy service interventions, and as such, was the prevailing mode of intervention adopted by all occupational therapy services to meet the patient's identified need across the pathway. (Acute (9/17), Primary Care (14/14) and Local Authority (21/23)) Equipment and adaptations, as an intervention, has the capacity to address patient functional dependencies at either a remedial level, where functional deficits are being compensated for by appropriately prescribed equipment and/or adaptations; or functions as a rehabilitative measure to develop the patient's functional abilities and/or prevent further deterioration in their condition and/or abilities. The subtlety of the status given to the equipment and adaptations intervention as either a service focus and/or a professional role by the occupational therapists within the discrete services provides a potential insight as to how the respective occupational therapy services perceived the role of the equipment and adaptation intervention.

Acute services acknowledged equipment and adaptations as a service focus (33%), but the prevailing occupational therapy role identified was unilaterally identified as discharge planning (100%), with functional assessments and referring on to other services as equally prevalent professional roles within service (66% respectively). The rehabilitative element identified within Acute services as the prevailing service focus was diminished to 33% when considered from a professional role in practice perspective. The guiding organisational imperative to facilitate the prompt discharge of clinically fit patients from hospital in line with the NHS HEAT target⁵² associated with Delayed Discharges⁵³, arguably created an impetus for the occupational therapy profession within Acute services to align their role to fulfill this specific organisational priority i.e. discharge planning. In the context of the Acute occupational therapy service being the only occupational therapy service being subject to the HEAT performance indicators, (measured in terms of patient numbers and throughput within pre-prescribed timescales), the role and prevalence of equipment and adaptations in providing immediate compensatory interventions to facilitate a safe discharge is conceivable.

Furthermore, the identified role of referring on to other services to promote continuity of care is also comprehensible within a time restricted service which is not in a position to deliver an extended comprehensive service. Despite no specific reference to the HEAT targets within the interviews per se, therapists alluded to constrained timescales arising from the pace of work within the Acute setting. Scenarios were outlined where an assessment, treatment (intervention) and discharge could occur within one and a half hours from receipt of a referral. In effect, the primary service focus of equipment and adaptations and referring on are interventions that provide the most proficient means for the profession within Acute services to fulfill their predominant perceived professional role of discharge planning. Despite the significant emphasis on discharge planning by Acute based occupational therapists, neither the Health based Primary Care service nor the Local

⁵² Scottish Government HEAT Target: Health improvement; Efficiencies and governance improvements; Access to Services and Treatment appropriate to individuals

⁵³ Delayed discharge indicator linked to "Treatment appropriate to individuals" HEAT target which states "no people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete"

Authority occupational therapy service registered this as a role within their responses.

Primary Care services did not acknowledge equipment and adaptations as a service focus and only one therapist (25%) perceived it as a professional role. This is despite the empirical evidence indicating that equipment and adaptations is the only mode of intervention provided by this service area. Therapists within the Primary Care service cohort acknowledged predefined service parameters in general terms e.g. 6 week timeframe for delivery of service; however, adherence to this timescale appeared somewhat flexible, as incidences were reported of pre service redesign interventions that exceeded this timeframe up to a period of six months duration. Consequently, given the relative degree of service autonomy in terms of the duration of service intervention, questions arise as to the apparent disconnect between the primary identified service focus and role of rehabilitation (75%) and the actual exclusivity on equipment and adaptations as a mode of service intervention within Primary Care (100%).

Primary Care occupational therapy services were established as part of a multidisciplinary Early Supported Discharge Team approach as part fulfillment of the Shifting the Balance of Care agenda. The service was developed to accelerate the discharge of patients admitted to hospital. It was hypothesised that such schemes could improve patient care by providing a seamless service that spanned the transitional period between Acute hospital care and being discharged home; a time that patients and carers frequently find difficult (Langhorne 2003). Primary Care occupational therapists did not overtly acknowledge their pivotal role in hospital discharge; nor did they appear to recognise the uniquely positioned multidisciplinary context the profession was placed in to execute this specific service role and function. The perceived (rehabilitative) and practice (equipment) disconnect is not justified by the Primary Care specific organisational context which emphasises a focus on facilitating hospital discharge through transitional service arrangements. Interestingly, this predefined role presents Primary Care occupational therapy services with a dichotomy as the empirical evidence highlighted Primary Care as the least effective service in reducing the number of transitions between occupational therapy services in the patient's transition from the hospital to the community. Primary Care occupational therapy services were only able to complete 3 of the 9

Chapter 5: Service Redesign -The Agency of Occupational Therapists (33%) in-reach /outreach test cases in comparison to their Acute and Local Authority colleagues (80% and 100% respectively).

Local Authority occupational therapy services identified equipment and adaptation as a primary focus within service (100%) and the legal and political priority of equipment and adaptations within the Local Authority occupational therapy service was acknowledged as an organisational service driver. The underpinning rationale as to the service focus was summed up by a Local Authority occupational therapist as

COT 1 “.....the Council employs O.T’s to deliver on the equipment and adaptation legislative duties and it (equipment and adaptation service) is a political priority in South Lanarkshire”.

Despite the centrality of the equipment and adaptations service focus within the Local Authority context, in terms of both the perceived service focus and the actual service activity, the espoused predominant professional role within the Local Authority cohort was identified as assessment and rehabilitation (50% respectively). The role of administering the equipment and adaptations resource was perceived as being a secondary role (33.3%) by the Local Authority occupational therapists.

The uniquely claimed professional role of “multidisciplinary working” identified within the Local Authority occupational therapy cohort (25%) is notable in that it is not reflected by either NHS based contingents. The service mapping exercise undertaken within the data gathering methodology illustrated the dependency of the Local Authority occupational therapy service on a range of parallel services and associated processes e.g. architects, surveyors, tradesmen etc in the planning and delivery of the extended equipment and adaptations resource (including major adaptations such as extensions which would not be undertaken by Acute and Primary Care occupational therapy counterparts). The rationale of multidisciplinary working being perceived exclusively as a key professional role by the Local Authority employed occupational therapists may be based on this premise. The NHS based occupational therapists in both Acute and Primary Care settings referenced the multidisciplinary context of their working environment within the extended format of the interview, but did not explicitly identify it as a primary professional role. This may, in part, be due to the relatively distinct nature of the NHS based services,

Chapter 5: Service Redesign -The Agency of Occupational Therapists highlighted with the mapping exercise as essentially independent from the parallel processes of aligned services. A further key notable variation in the perception of role scope and service emphasis emerged across the three service sectors that serves to provide an insight into the contextual basis for differences in the perceived roles and functions of the respective occupational therapy services. A clear distinction was noted between the Health contingent response i.e. Acute Care of the Elderly and Primary Care services and their Local Authority counterparts. Health occupational therapists intimated a specific managerial role (66% and 25% respectively), whilst the Local Authority service did not cite this as a specific remit within their operational duties. This possibly reflects the different organisational hierarchal structures within Health and Local Authority services. Within Health, practising occupational therapists can incrementally assume management responsibilities through a graded management structure that accommodates a continued frontline practice remit, whereas Local Authority occupational therapy structures employ occupational therapists as either frontline practitioners or as managers without a direct frontline practice responsibility. Despite both Health and Local Authority occupational therapy cohorts having representation from management and frontline practitioners, the responses demarcate a distinctive nuance in how occupational therapists perceive their role in the context of their employing body's organisational structures.

These reflections begin to reveal the therapist's perceptions illustrating shared perspectives in respect to the service focus and the profession's primary role, albeit to varying degrees. Key fundamental differences in the scope and nature of occupational therapy services also emerge as does an incongruity between the perceived service focus and the primary role of the respective occupational therapy services. Inconsistencies in these professional perceptions vis a vis the actual occupational therapy service activity, highlighted through the empirical data analysis, create an additional misnomer for enquiry. The provisional descriptors of the potential influences within the discrete occupational therapy services begin to reveal different organisational contexts within which the profession operates. The perceived influence of these organisational influences as service drivers are investigated in efforts to explore the agent /structure interaction and hypothesise as to the potential causal explanations in relation to the service redesign outcomes.

5.2.2. Occupational Therapy Services: Perceived Service Drivers and Service Outcomes for Patients

The predetermined organisational drivers operationalised through service standards and performance measures were acknowledged by all but one therapist as having varying degrees of influence on their practice. However, 10 of the 13 therapists (77 %) were resolute in claiming that the nature of patient need was central to influencing the type of service activity undertaken. Irrespective of the perceived organisational influences, all therapists without exception claimed that the professional practice within service was person centred, but universally inferred that the impact of organisational drivers undermined the person centred approach to care. The following statements are extracts from the interview schedules that reflect the sentiment and perceptions of the occupational therapists across Acute, Primary Care and Local Authority Services:

COE 2 “Person centred because it’s about the patient but organisational because patients have to be prioritised and therapists prioritise patients with equipment and homecare needs over other patients” (presumably to facilitate discharge).

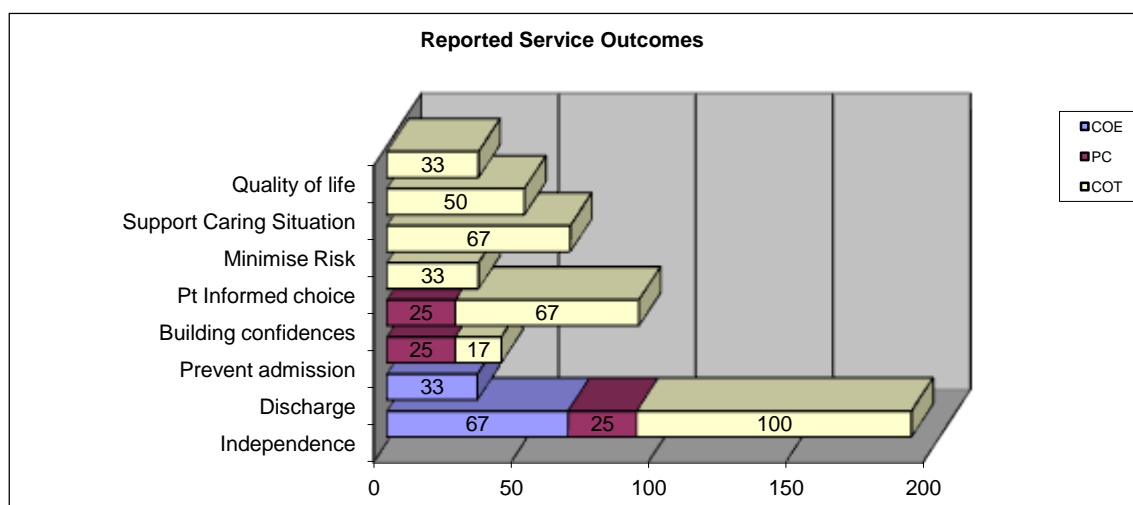
PC 2 “Predominantly person centred but within the confines of the organisational context that can limit the time you can give to a patient” (in reference to 6 week service timeframe)

COT 6 “Organisationally driven by guidelines and limitations... we are gatekeepers to our service (in reference to equipment and adaptations), though we try to treat each person as an individual”.

The centrality of the patient within the respective services was ultimately validated by the therapists themselves through their self-reported person centred service outcomes. These occupational therapy perceived outcomes claimed a broad spectrum of benefits to the patient, demonstrating a shared positive perspective as to the value of their respective services. Graphs 6 provides a synopsis of the

Chapter 5: Service Redesign -The Agency of Occupational Therapists reported person centred outcomes arising from occupational therapy interventions as described by the occupational therapists.

Graph 6: Occupational Therapy Reported Person Centred Outcomes



All three service sectors universally reported increased levels of patient independence as a service outcome arising from occupational therapy service intervention (Acute 66%, Primary Care 25% and Local Authority 100%). Building patient confidence was reserved as a Primary Care (25%) and Local Authority (67%) specific patient outcome; whilst singleton therapists within both Primary Care and Local Authority also shared the perspective that their respective services prevented hospital admission. Acute Care of the Elderly occupational therapists identified the hospital based occupational therapy service as being instrumental in facilitating hospital discharge, though this was only expressed by one therapist, despite all 3 identifying it as a professional role. Finally, the Local Authority occupational therapy service, in addition to the outcomes shared with their Acute and Primary Care based colleagues, articulated an extended range of perceived patient outcomes arising from their service interventions. These included minimising risk (67%), supporting the caring situation (50%) and providing the context for patients to make informed choices (33%).

Within the context that the prevalent mode of intervention with Acute, Primary Care and Local Authority services is the provision of equipment and adaptations (81.5%), these perceived person centred outcomes are intriguing. Indeed, the professional

Chapter 5: Service Redesign -The Agency of Occupational Therapists

prescription and provision of equipment and adaptations has the capacity to realise all of the identified person centred outcomes. However, other than the universally cited outcome of increasing levels of patient independence, arguably an aspiration of all service sectors, the therapists' account of the outcomes achieved bear a distinctive alignment to their respective employing organisation's primary operational and strategic objectives i.e. the Acute occupational therapists being influenced by their employing body's objective to meet the central government mandated HEAT performance measures in terms of facilitating hospital discharge; the Primary Care occupational therapy service's perceived rehabilitative focus within the community as serving to increase the confidence of patients and prevent hospital admission as fulfillment of their Shifting the Balance of Care mandate; and the Local Authority occupational therapy service proclaiming an extended range of person centred outcomes which befit the aspirations and responsibilities explicitly embedded within Local Authority legislative and policy related drivers e.g. Social Work (Scotland) Act (1968), Chronically Sick and Disabled Persons Act (1972), Equipped for the Inclusion (2003)

The legitimacy of some of these perceptions cannot be validated or otherwise within the scope of this research. The perceived patient benefits of "building patient confidence", preventing hospital admission", "minimising risk" and promoting "informed choices" are outwith the scope of this research's area of investigation. This research's empirical data does however provide some useful provisional insight as to the actual service activity and impact of the Acute, Primary Care and Local Authority occupational therapy services on patients and carers. The results suggest that the occupational therapy service is largely unresponsive to the assessed needs of the patient cohort. The value of the occupational therapy services in terms of the perceived benefits to patients is, in some respects, also questionable.

5.2.3. Occupational Therapy Services: Perceived Outcomes for Informal Carers.

The role of the occupational therapy services in supporting the informal caring arrangements is also reflected within this research and serves to further inform and contextualise the potential rationale for the mode of interventions provided by the

Chapter 5: Service Redesign -The Agency of Occupational Therapists
discrete occupational therapy services across Acute, Primary Care and Local Authority services.

The empirical data reflects that carers provide significant support to patients with dependencies. 58.4% (108/185) of all assessed dependencies were being mitigated by informal care. The Local Authority based occupational therapists were the only staff cohort to espouse supporting the informal carer as a specific occupational therapy role; however, the data suggests that all three services, whether intentionally or not, provided some support to carers. The three occupational therapy services provided carer support in 20.4% (22/108) of all caring situations⁵⁴ (Acute 8, Primary Care 5 and Local Authority 9). Where occupational therapy services provided an intervention within the caring situation, patient levels of independence increased in 45.5% (10/22) of the cohort. Within the cohort of patients supported by carers that did not improve, 46.7% (5 of the 12) declined occupational therapy intervention. 4 of these occurred within the 8 interventions offered within the Acute occupational therapy service and the fifth was 1 of the 5 interventions offered by Primary Care Services.

All 9 interventions offered by the Local Authority occupational therapy service were accepted by the patients and their carers. This, combined with the apparent success of the Local Authority interventions in promoting levels of independence with this group (77.8%,7/9), supports the therapist's perception that supporting carers is a significant role in Local Authority practice. The presumption is that the beneficial outcome of any improvement in patient independence would be to ease the caring role. Any additional benefits to the caring situation where occupational therapy intervention was accepted but patient dependencies did not change can only be speculated. One such speculation would be that the intervention provided carers with resources to support the caring situation e.g. equipment or adaptation to assist in activities such as moving and handling patients. The extent to which occupational therapy intervention supported carers in the caring role rather than removed or reduced the caring responsibility is not within the scope of this research, but inferences can be made as to the potential benefit of such interventions.

⁵⁴ Excluding the 15 carer situations within bladder and bowel MBI categories

Conversely, health based colleagues, whether within Acute or Primary Care services, did not overtly acknowledge supporting carers as a primary role, despite evidence to indicate that support was provided, albeit as a consequence of interventions targeted on the patient. Observations of an Acute occupational therapist crystallised the difference in the perceived status of the professional role in supporting the carer. The following statements were made on reflecting on the experienced practice differences between Local Authority occupational therapists and Acute occupational therapists practising within an Acute ward setting (as part fulfillment of the inreach /outreach measure adopted within the service redesign).

“COT4 (in reference to Local Authority OT) undertook a washing and dressing assessment on the ward, where Acute staff (occupational therapy) would not as the carer undertook the role”.

This was qualified with the following statement that inferred that the practice norm within the Acute occupational therapy service would be to prioritise areas of activities of daily living that were not supported by a carer.

“...we have to be very selective about the types of interventions we pick up because we don't have the time to check out all the ones that don't need checked out”

Despite this perception, the evidence would suggest that Acute based occupational therapists do not circumscribe the support provided to patients in receipt of informal care in practice as 47.1% (8/17) of the service's interventions were directed to patients with recognised informal support arrangements in situ. The evidence also reflected that 35.7% (5/14) of the Primary Care occupational therapy service's interventions, directly or inadvertently, supported patients in activities of daily living where they were in receipt of informal care. Occupational therapy service interventions with patients with dependencies that did not have informal carer support equated to 26% (20/77). Of these, 55% (11/20) demonstrated improvements following occupational therapy intervention as reflected within their MBI post intervention rating.

These results portray an inter-organisational occupational therapy service as a conundrum, characterised by an incoherent and inconsistent approach, resulting in service misdirected practice and fragmentation; yet the results also indicate that occupational therapy intervention, appropriately directed, can result in quantifiable benefits to the patient and inferred benefits to the carer. The espoused perspectives of the occupational therapists on the perceived service focus and drivers, professional role and service outcomes within their respective organisational contexts, highlights the extent of the profession's misperception and provides some indication as to the existence of potential inter and intra-organisational and professional variation and tensions.

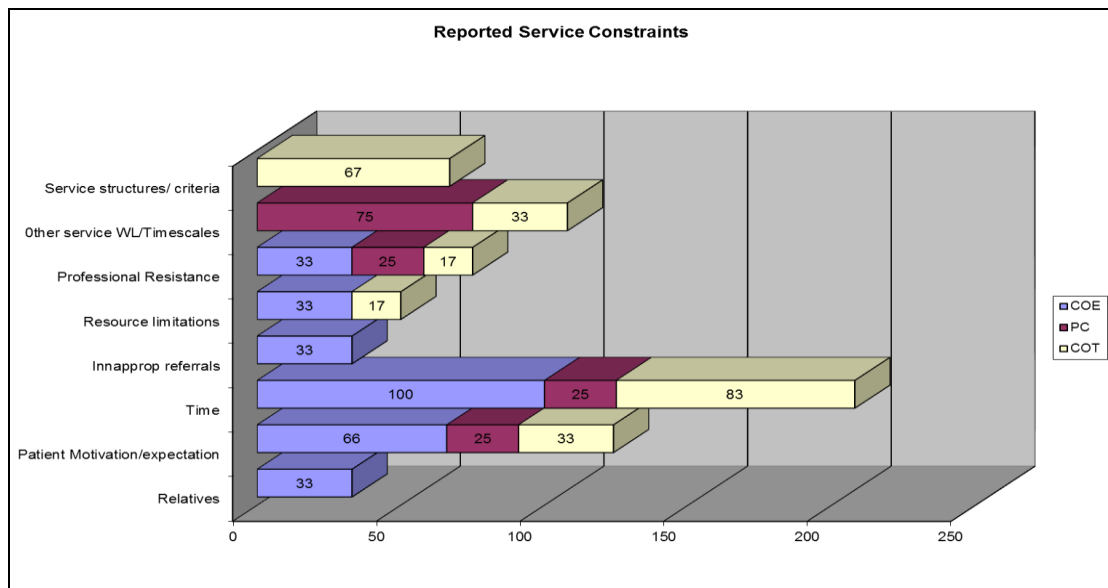
5.2.4. Occupational Therapy Services: Perceived Service Constraints and Service Facilitators

The occupational therapists interviewed were provided with an opportunity to express what they considered to be either a constraint or facilitator within their respective services in delivering the aspirations of the professional service. The objective was to explore the therapists' pre-existing agential relationship with their respective service structures and practice contexts. The emerging mindset(s) served to inform the conceptualisation of their subsequent perceptions and behaviours in response to the measures introduced within the service redesign.

5.2.4.1. Service Constraints

Graph 7 provides a summary of the therapists' perceptions of the primary service constraints within their respective services and provides an overview of these as a collective account.

Graph 7: Occupational Therapy Reported Structural Constraints



The primary whole system service constraint was identified as time (69%). However, the emphasis placed on this varied across services. Acute Care of the Elderly and Local Authority occupational therapy services considered it the singularly most constraining variable within service (100% and 83% respectively). The Acute and Local Authority occupational therapy cohorts shared the view that limited time with patients had ramifications on the timing, quality and appropriateness of service interventions provided by their respective services. The identification of service time constraints provided Acute services with an opportunity to reflect and acknowledge that the service's primary espoused role of rehab was being compromised. This was qualified within the context of the quick turnover of patients and thus their perceived focus being diverted to activities associated with hospital discharge. The Local Authority contingent equally viewed the rehabilitative element as being a primary service intervention not being realised and considered it as a significant service gap across Acute, Primary Care and Local Authority services. The impact was considered as negative as patients were viewed as not reaching their potential.

Notwithstanding the limited availability of timely rehabilitative services, the therapists across Acute, Primary Care and Local Authority services shared the perspective that patient motivation and expectation also contributed as a constraining variable within

Chapter 5: Service Redesign -The Agency of Occupational Therapists

their respective services. Patients within Acute and Primary Care services (66% and 25%) were cited as not complying with the intervention objectives within the service timescale parameters. This perception undermines the previously espoused person centred approaches to practice and reintroduces some questions as to actual impact of the organisational constructs in determining and constraining practice. Patient motivation and expectation were also recognised as a constraining influence within Local Authority Services (33%). A distinction is however drawn between the services in that Acute and Primary Care service occupational therapists perceived the constraint under the auspices of patient motivation, whilst Local Authority practitioners acknowledged the constraint in terms of fulfilling patient expectation. Descriptors by the Local Authority occupational therapists reflect a professional dichotomy. On the one hand, being an advocate, with the interests of the service user as paramount, whilst simultaneously assuming a “gatekeeping” role in tempering patient’s and carer’s expectations through the application of service criteria informed through an assessment of need. The impact of this on patients and carers is reflected in the comment which differentiates between what is described by the therapist as a “want” and a “need”,

COT 1 “... so instead of a stairlift, the service user (patient) will get a handrail”

The expectations of relatives were also noted within Acute services as a service constraint (33%) as some relatives were perceived to pursue services that provided “care” for their family member as opposed to rehabilitative or re-enabling focussed services that promoted levels of patient independence. The contention in this would be the resulting unfulfilled potential of the patient. However, the empirical evidence suggests that the incidence of rehabilitation resulting in an increased level of patient independence following occupational therapy intervention is proportionately half that of those who receive equipment and adaptations as the mode of service intervention (Table 11). The immediacy of a measureable improvement arising from equipment and adaptations may contribute to this presentation. However, the challenge in delivering any meaningful rehabilitative intervention in the context of the service’s reported time constraints would appear unrealistic.

Time was not perceived as a major constraining factor within Primary Care services. Although acknowledged, it did not appear to reflect the same level of significance within existing practice. The only reference to it within the context of existing service arrangements was the logistics of timing occupational therapy interventions in synch with physiotherapy sessions and the practicalities of attributing significant amounts of time to cover the expansive geographical area the service was required to cover. Primary Care service's most prevalent espoused issue in respect to time was reflected in the context of assuming additional responsibilities within the service redesign.

The excerpt from appendix 7 data analysis below reflects the explicit reference to time as a specific category by the Primary Care occupational therapist (code PC 1) who after stating "time" as a service constraint explained

PC 1 "...we had other people whose needs were just as important than the test cases...it was time consuming....instead of coming into our service it could have been passed back to social work.....I didn't see anything potentially leaving my desk"

Table 12. Data Analysis Extract

		COE%	PC%	COT%	CoE	PC	COT
Service Constraints	Relatives	33%	0%	0%	1	0	0
	Patient						
	Motivation/expectation	67%	25%	33%	1,3	2	2,3
	Time	100%	25%	83%	1,2,3	1	1,2,4,5,6
	Inappropriate referrals	33%	0%	0%	1	0	0
	Resource limitations	33%	75%	17%	3	1,2,4	1
	Professional Resistance	33%	25%	17%	3	4	1
	Other service						
	WL/Timescales	0%	75%	33%	0	1,2,3	1,2
	Service structures/ criteria	0%	0%	67%	0	0	3,4,5,6

The most predominant identified constraining factor within this service was lack of resources, with 3 of the 4 Primary Care based occupational therapists (75%) citing this as a service limitation. Interestingly, this perception revisited previous observations presented by this cohort of therapists under organisational structures and priorities considerations. The lack of resources referenced referred to resource constraints exclusively within external services rather than resources internal to the Primary Care occupational therapy service itself e.g. homecare, transport. Acute and Local Authority based service therapists also acknowledged lack of resources

Chapter 5: Service Redesign -The Agency of Occupational Therapists as a resource constraint. However, the resource concerns were acknowledged as both internal and external to their respective services. Within the Local Authority sector, therapists identified their role as “gatekeepers” to the equipment and adaptations service as an indicator of the limited in-house resource within service; but also acknowledged external resource constraints imposed by Housing Association’s funding restrictions to meet the specific adaptation needs of their tenants. This is reminiscent of the reliance of parallel services and processes to deliver on the assessed needs of patients for the equipment element of the equipment and adaptation focussed service; and simply denoted an additional reliance on another service for the adaptation element.

Acute service based occupational therapists were the only therapists who specified the lack of resources within their service as being related to their own service staffing resource. This was in reference to backfill arrangements of in-service staff to provide interim cover for incidences where a post holder was not able to undertake the remit of the post. In contrast to their Primary Care and Local Authority counterparts, Acute based occupational therapists did not identify limitations in resources within external services as of significance in presenting operational constraints in delivering services to the patient during the interviews. However, this was a theme reflected within the mapping exercise. Acute occupational therapists referenced the reliance on porters to bring patients to the department timeously, suggesting service disruption if delays were incurred and also identified the non-availability of Local Authority homecare services as detrimentally impacting on discharge planning.

Despite some of these identified organisational resourcing issues, the pre-existing organisational structures and priorities with Acute and Primary Care occupational therapy services were paradoxically not perceived as a service constraint. Indeed, the Local Authority occupational therapy service was not only singular in identifying the existing structures and criteria as a constraint on service, but was exceptional in their perception in naming it as the most prevailing limitation (66.8%). This is despite Local Authority services arguably having more flexibility in respect to certain service parameters e.g. patient length of stay, unobserved practice. The equipment and adaptation resource was however perceived by the staff group as the solitary

Chapter 5: Service Redesign -The Agency of Occupational Therapists

service intervention at the therapist's disposal within the existing service structure. Furthermore, the assessment standard of 28 days was viewed as exacting, as was the political overruling of professional recommendations in favour of constituents who lodged complaints about the type of equipment and/or adaptation prescribed. This may contribute to the therapist's perception of service structures and criteria being a constraint in the context of delivering on the extended service outcome aspirations voiced by the Local Authority occupational therapists.

In contrast, despite the recognised organisational service timescales imposed on both Acute and Primary Care occupational therapy services, the occupational therapists did not appear to attribute any inadequacy in meeting the service focus or professional role in practice to organisational service structures and criteria. The divergence in perspective between Local Authority and Health based occupational therapy services on the issue of the impact of organisational structures and service priorities on services is intriguing. Whether this relates, in part, to the fact that the Local Authority occupational therapists appear to have acknowledged and conceded that there is a marked discrepancy between their employing organisation's service focus and the extended professional role they would aspire to fulfil, whilst their health counterparts appear not to have acknowledged this disconnect to the same extent. The empirical evidence and the statements made by the therapists during the semi structured interviews, would suggest Acute and Primary Care colleagues appear to be under a misapprehension that the espoused professional aspirations are in line with their employing bodies service focus and are mistaken in thinking that this is being realised in practice. Effectively, the question posed is whether Health based occupational therapists are oblivious or in denial to the potential ramifications of their organisational structures and criteria on practice, or are there indeed other key variables that conspire to constrain the actual service delivered in practice?

The constraining variables, as perceived by the practising occupational therapists, are notable as being identified factors that are external to the therapist and the profession. The identified external variables outlined amount to 91% of the perceived constraints within the Acute, Primary Care and Local Authority occupational therapy services. The remaining 9% of the identified service

Chapter 5: Service Redesign -The Agency of Occupational Therapists

constraints reflects a more intrinsic perspective to the self-perpetrated limitations arising from the therapists themselves. All three service sectors identified professional resistance as a constraint; although reference to it was more specifically in relation to the challenges faced through the service redesign rather than the existing service arrangements. Therapists across all sectors made emphatic statements that staff consciously made decisions as to the professional specialism and area of work they wished to be employed in. The value placed by therapists on the discrete organisational structures of choice and the apparent allegiance to those system and practice norms manifested in the perceptions and behaviours within practice. During the semi structured interviews, references to the heightened expectations on staff in undertaking the additional roles in order to execute the in-reach /outreach service model, had negative connotations. The staff concerns expressed included the simple practical task of donning uniforms by Local Authority occupational therapists to engage in the Acute Care of the Elderly element of the occupational therapy service patient pathway. This relatively menial task appeared to represent the embodiment of institutional care that community based Local Authority occupational therapists were not familiar with and clearly reluctant to assume.

COT 4. "Didn't hang about (in the hospital) to do rehab so I didn't need to put on the uniform"

COT 2. "Such a different environment...I don't know if would like to do it full time ...not for me!"

The reluctance of Primary Care staff to get involved in the institutional Acute phase of the patient pathway was also evidenced in the empirical data. Although this was not uniform related, as this was their normal mode of professional attire, Primary Care therapists unilaterally avoided, and were successful, in not undertaking any Acute element of the patient pathway. Their preference was to engage in the community based activity associated with the traditional Primary Care and extended Local Authority elements of the occupational therapy service. This was despite the Primary Care espoused service focus being synonymous with the Acute occupational therapy service focus; a baseline which would suggest the potential for an affiliated practice approach.

PC 4. "I did what I wanted into the community (referring to inreach/outreach measure)...don't think I would have enjoyed it if I had to deal with a patient in the ward...who knows how long you would have to deal with them in the hospital...taking them to kitchen practice etc"

Finally, although the Acute occupational therapy service personnel did assume the extended role within both the Primary Care and Local Authority phases of the patient pathway, they shared significant reservations about disengaging from the routines associated with the traditional multidisciplinary service constructs and struggled with the implications of assuming the extended role. Fundamentally, the expressed concerns related to the impact on their perceived professional status by Acute service colleagues within the multidisciplinary team. The extended role which promoted following the patient through the care pathway in entirety, created a tension, as therapists were removed from the familiar and established confines of the hospital and ward setting and could no longer function as the single occupational therapist representative within that context. Therapists appeared to be acutely aware of the professional status of other allied health professions within the multidisciplinary team and expressed concerns in respect to not being able to report on patients directly, like their physiotherapy colleagues. The impression presented during the semi structured interviews was that this was construed by the Acute occupational therapists as a professional disadvantage.

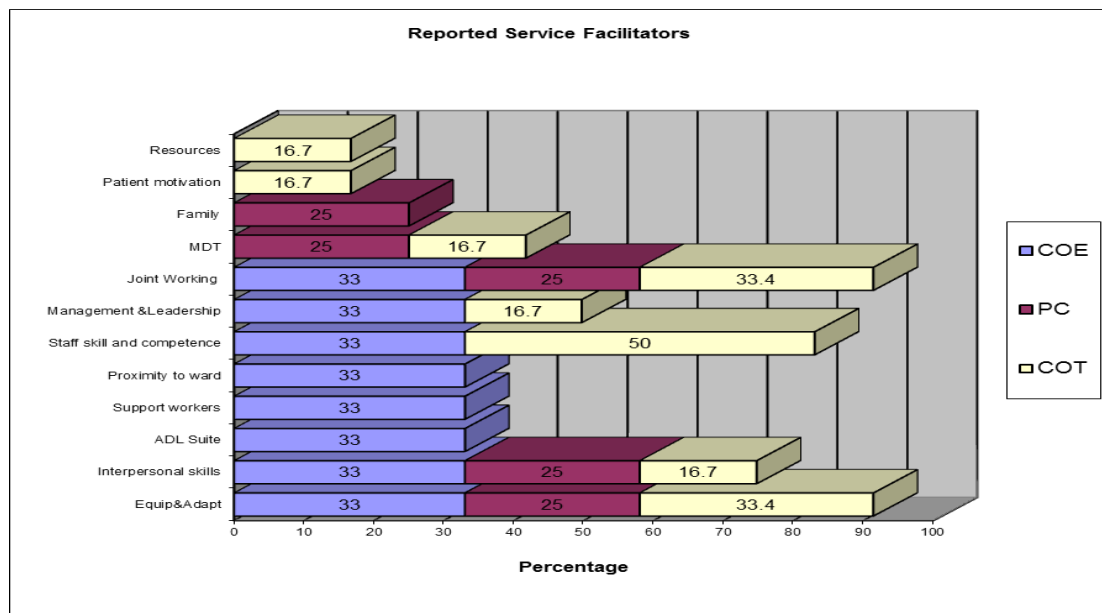
COE 2 "There were difficultiesnot being part of a team but being an outsider....being behind the physio in terms of the patient process and not getting updates"

The therapist's pre-existing value bases entrench and restrict service and professional development through their ability to self-select the parameters of practice, both within the auspices of current service activity and within service developments.

5.2.4.2. Service Facilitators

The espoused service facilitators present a dispersed response, with individual therapists identifying a range of variables, with little discernible consensus on prevailing whole system service facilitators. However, what is discernible is that occupational therapists across Acute, Primary Care and Local Authority services attributed 83% of the variables that were perceived to support the delivery of services to external influences; whilst 17% were attributed specifically to the inherent skills and abilities within the occupational therapy practitioner staff group. Graph 8 provides a summary of the therapists' perceptions of the primary service facilitators within their respective services and provides an overview of these as a collective account.

Graph 8: Occupational Therapy Reported Structural Facilitators



The four areas identified by all three service sectors were in the areas of joint working, interpersonal skills, equipment and adaptations and external resources. The sentiment underpinning the identification of these espoused facilitating variables differed within the respective services. The Health sector based Acute and Primary Care occupational therapists referred to the joint working arrangements in terms of direct access to a range of Local Authority resources and agencies e.g. equipment and adaptations and extended social care supports. This interpretation of joint working is inadequate, as the therapist accounts related exclusively to the systems

Chapter 5: Service Redesign -The Agency of Occupational Therapists and processes associated with joint working rather than the professional synergy in approach to the delivery of occupational therapy services. Conversely, Local Authority occupational therapists relayed the benefits of joint working in terms of interpersonal relations fostered within the Local Authority team culture and referred to the facilitating nature of their immediate team colleague's support in practice. This perspective of joint working, although constructive at an intra-organisational level, is void of the inter-organisational dimension central to, and promoted by, contemporary central government service development strategies.

The interpersonal skills referred to by the therapists within all three discrete services alluded to a collective professional strength in communicating with patients and their carers. The Acute perspective attributed this to the profession's intrinsic "professionalism and attitude"; Primary Care perceived the profession's interpersonal skill set as core in giving advice and encouragement and establishing and coordinating services to support patients and their families; whilst the local authority inferred the profession's interpersonal skills was based on an empathy with the patient's and carer's perspective and was implicit with the process of assessment and intervention activities. This fundamental skill was perceived as central in building confidence in patients and teaching alternative ways of undertaking activities of daily living, with or without equipment and/or adaptations.

The third facilitator identified within all three services was the equipment and adaptations resource. The numbers of therapists citing it as a facilitator in service delivery was relatively low (4/13, 31%), but the relevance of it is underpinned by the prevalence of equipment and adaptations as the actual predominant mode of service intervention across all three service sectors (81.5%). Irrespective of the conscious acknowledgement of its role/status within service, the equipment and adaptation resource, when referenced by the 4 therapists, was universally acknowledged as having particular value in increasing levels of patient independence and promoting safe discharges.

The facilitating role of external resources and influences was identified by singleton occupational therapists within each of the respective services. The variations in the external commodities that were identified as supportive in practice appeared to

reflect the nature of the perceived service focus and professional role within the Acute and Local Authority services. The Acute occupational therapy representation espoused a perceived value to two primary environmental specific considerations and an associated departmental staffing resource that supported the professed rehabilitative service focus. The first was the proximity of the occupational therapy department to the ward setting, which allegedly provided ease of access to the patients; though this was not borne out in the tracking data which demonstrated that the hospital based occupational therapists spent more time walking between wards and the department than their community based counterparts, who were required to travel by car between patients' houses (Acute 17.48%, Primary Care 16.46% and Local Authority 14.01%). The second environmental consideration was the department's Activities of Daily Living suite, which was considered to facilitate intensive patient rehabilitation in activities of daily living. This facility was perceived as being further enhanced by the availability of support workers whose role was to assume the rehabilitation practice under the instruction of a qualified therapist. These reflections maintain and validate the misplaced Acute occupational therapy perception that the service activity is on rehabilitation.

The perceived service focus on equipment and adaptation, validated within the empirical data, is confirmed in the Local Authority reflections as to the service facilitators in practice. The account during the semi structured interview describes accessibility to the EquipU equipment store and good working arrangements with housing providers to fulfil the equipment and adaptations requirement of the post. The response also acknowledged the employing authority's commitment to the equipment and adaptations resource through levels of funding that were perceived as favourable in comparison to other Local Authorities; despite previous assertions that therapists were required to act as "gatekeepers" to this scarce resource.

The description offered by the Primary Care contingent was far reaching and encompassed a variety of external resources that appeared to reflect a coordinating role of community based patient supports. These included family supports, social work support packages, equipment, befriending projects, social networks and other agencies. The inference was that these elements provided the Primary Care service with the capacity to support a patient within their home environment. This account

Chapter 5: Service Redesign -The Agency of Occupational Therapists does not in itself undermine the status of the perceived and espoused rehabilitative focus within service. Indeed, these resources, appropriately sourced, could prevent hospital admission as part of a community based intervention support package. However, unlike the Acute and Local Authority service reflections on external resources, the Primary Care portrayal of service facilitators does not appear to be entirely congruent with their stated perceived service focus of assessment and rehabilitation.

Further variables were identified by a combination of two occupational therapy services. The first related to the multidisciplinary team (MDT) structure. This, unsurprisingly, was identified by the Health based occupational therapy personnel. It was cited by two of the three Acute representatives (66%) and one of the four Primary Care therapists (25%). Acute service personnel specifically expressed a vehement fidelity to the MDT structure with marked reservations about deviating from that service construct in the interests of professional preservation within the Acute sector. The perceived personal worth of working within the Acute sector was palpable within this group of staff. The comments by two of the three Acute service personnel were emphatic in describing their conscious choice to be employed within the Acute service sector over the community based Primary Care or Local Authority services.

Primary Care based therapists referenced MDT structures, albeit in name only, with very little in justification or explanation. This level of response by the Primary Care therapists is particularly notable, as the Primary Care service is the only service out of the three service areas that is constructed within a multi professional team configuration, comprising of a range of nursing and allied health professionals, including occupational therapy. Both the Acute and Local Authority services are discrete occupational therapy teams or departments that practise within single professional structures that interface with the extended MDT from an inter and intra organisational perspective. Interestingly, it is this uni-professional team structure that is heralded by Local Authority therapists as a specific strength and facilitator in practice. The value of an occupational therapy specific service structure within the Local Authority context may be derived from the fact that this professional cohort is the only group out of the three occupational therapy services employed within a

Chapter 5: Service Redesign -The Agency of Occupational Therapists
secondary setting. The structure, previously denoted by the Local Authority occupational therapists as a service constraint within the realms of the organisation, is now deemed by the Local Authority therapists as a service facilitator from the perspective of what is referred to by the therapists as a service support infrastructure that promotes staff resilience in practice.

Staff skills and competence within service was reflected by both the Acute and Local Authority contingents (33% and 50% respectively) as a facilitator. The skills of occupational therapy personnel within Acute Care of the Elderly was intimated in general terms and was not elaborated on; whereas the Local Authority claimed and specified an expert knowledge in assessment, problem solving and the associated prescription of equipment and adaptations to meet the needs of patient, not only in the short and medium terms, but also in accurately predicting the needs of patients in the long term. The need to be evidence based to reflect reasoning and justification for decision making was relayed in the context of the political arena, whereby occupational therapists perceived that professional decisions could be overruled. Robust practice standards were viewed as the service's defence mechanism to mitigate against such incidences. The competence of the management and leadership within both the Acute and Local Authority practitioner groups were also identified as facilitators within service (33% respectively). Acute management referred to robust management systems that were in place within the department, the quality of training and the leadership within the department, all of which created a perceived context that facilitated the successful delivery of services and supported service developments. The Local Authority practitioners made positive reference to the management support generally, with specific reference to the intelligent allocation of workload being of particular support; an action of particular value in a service that generates a high volume of referrals.

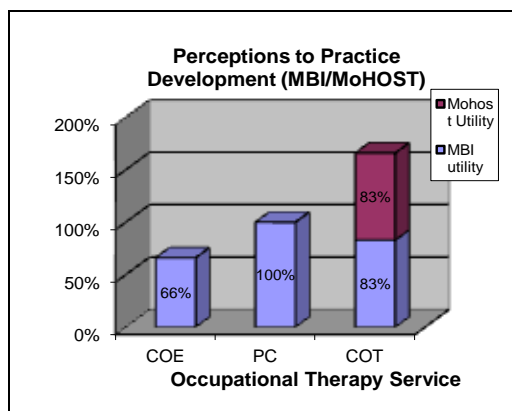
5.3. Service Redesign Measures: Occupational Therapists' Reported Perceptions of In-practice Experience

Graphs 9, 10, 11 and 12 highlight the occupational therapists perspectives on the implementation of the four service redesign measures. The occupational therapists' perceptions of the service redesign measures provide an insight into the rules that

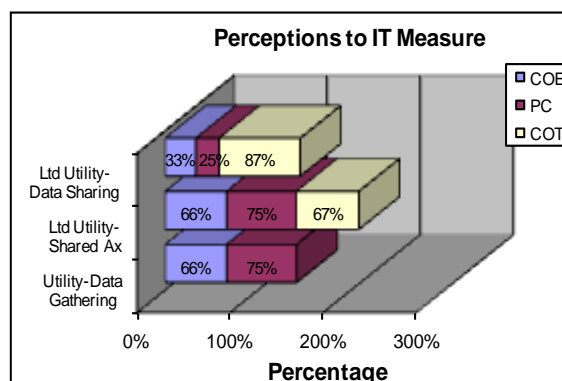
Chapter 5: Service Redesign -The Agency of Occupational Therapists constitute and regulate activities, defining the parameters of acceptable activity and creating sanctioned limits within service.

Graphs: Occupational Therapy Perceptions of Service Redesign Measures

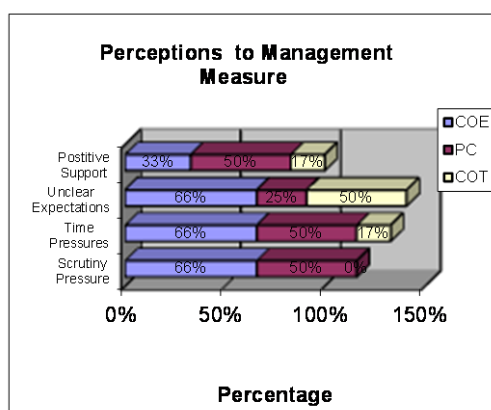
Graph 9



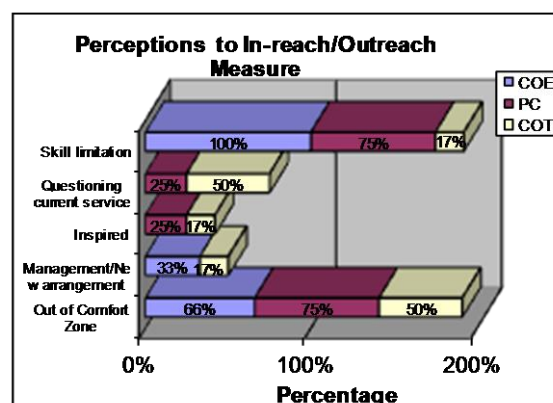
Graph 10



Graph 11



Graph 12



5.3.1. Unified Practice Approach: Occupational Therapists' Perceptions

The service redesign was underpinned by the introduction of a unified practice approach to occupational therapy services across Acute, Primary Care and Local Authority services. This was encapsulated in the introduction of the Modified Barthel Index (MBI) and the Model of Human Occupation Screening Tool (MoHOST). The MBI is a 10 point ordinal scale used to measure performance in a range of activities of daily living and serves to reflect dependency levels of patients in receipt of the respective occupational therapy services. The MoHOST is an occupational therapy specific practice applied measurement tool that seeks to explain how occupation is

Chapter 5: Service Redesign -The Agency of Occupational Therapists motivated, patterned and performed through a patient's volition, habituation and performance capacity.

5.3.1.1. Occupational Therapists' Perceptions: Modified Barthel Index

Graph 9 illustrates the perceived utility of the MBI tool. 11 of the 13 therapists (85%) indicated it resonated with the service activity and practice and was valued by these therapists in terms of demonstrating functional capacity outcomes arising from service interventions. It was also considered as simple to implement, not time intensive, and a general confidence was expressed in articulating the results within a range of forums. The MBI tool's strength was that it was familiar to many of the occupational therapists involved, and as a generic tool utilised by a range of public service professional disciplines within care of the elderly services. Its efficacy in communicating results inter-organisationally and between professional disciplines was perceived to be of significant value.

The almost universal acceptance of the MBI tool appeared to be justified; however, an audit of the tool's usage within the service redesign research site presented an empirical reality that questions the inter-tester reliability of the tool in the context of how it was being applied within the research site. Of the 33 completed MBIs, 20 of the patient cases from Acute and Primary Care services were subject to informal peer scrutiny. This peer evaluation occurred as a consequence of the buddying arrangement as part fulfilment of the in-practice training structures and as a result of the 8 incomplete cases being transferred to Local Authority occupational therapy services for completion. The Local Authority MBI documentation was not subject to the same level of peer evaluation, as all test cases originating from Local Authority occupational therapy services were complete and were therefore not subject to in-practice peer evaluation. Of those subject to peer evaluation 25% were identified as having significant differences in dependency ratings, with a scoring differential of up to 39 points within a scoring structure of 100. This represents a difference between patients being assessed as having severe levels of dependency to having minimum levels of dependency. No patterns emerged in respect to personnel or services involved and there did not appear to be regularity, within the sample, of overrating or underrating practices from specific sources. The ramifications of this scoring

Chapter 5: Service Redesign -The Agency of Occupational Therapists

differential were evidenced in the inappropriate interventions provided or in the absence of interventions that were required.

The case example Patient X demonstrates the case. Patient X was assessed by Acute occupational therapy service as having a dependency score of 62 (moderate level). The Local Authority occupational therapy service at the point of transition assessed Mr X as having a dependency score of 35(severe). No acute medical episode was reported and the independent assessments occurred within 10 working days of each other. The key areas of dependency identified by the Acute occupational therapy service related to bathing, toileting, stairs and mobility. The interventions delivered by the acute service were 19 episodes of transfer practice from wheelchair to bed with a transfer board, despite the Acute service MBI assessment not registering dependencies in this area. No other interventions were undertaken and Patient X was discharged from Acute services as an incomplete test case. The Local Authority occupational therapist assumed responsibility for patient X when Patient X was still an in-patient within the Health setting, as the intention was the Acute occupational therapist would extend their duty of care and support the patient's discharge from hospital, buddied by the Local Authority occupational therapist to support the complexities of the discharge arrangements back home. This was not realised as patient X had been transferred off site to an ancillary hospital and the Acute occupational therapist was not independently motivated to work off-site. The Local Authority occupational therapist's assessment of patient X indicated a patient presentation that was significantly different with levels of functional dependencies that were classified as *severe* in the MBI categorisation system. The support provided by the Local Authority occupational therapist to facilitate the discharge home included a range of compensatory interventions through the provision of a range of specialist equipment and adaptations within patient X's home environment. These measures responded to the identified areas of dependencies relating to bathing, toileting, transfers and dressing. The dependencies identified within personal care, stairs and mobility were not addressed through occupational therapy intervention.

As a consequence of the chasm in approach to the care and support of patient X, the dynamics of a buddying relationship was undermined, as the Local Authority's

Chapter 5: Service Redesign -The Agency of Occupational Therapists

assessment of patient X called into question some of the Acute occupational therapist's assessment competencies. This position was affirmed by the service redesign coordinator who undertook a dual assessment of patient X. The impetus to enforce and support staff through a learning programme was challenged in this instance as the urgency to fulfil the complex discharge needs of patient X timeously took precedent. The priority was to undertake the required work without the distraction of addressing fundamental practice failings and the anticipated associated emotive responses from the occupational therapy personnel involved. Patient X died six months post discharge.

Table 13. Case Example: Patient X

	Personal	Bath	Feed	Toilet	Stairs	Dress	Bowel	Bladder	Mobility	Transfer	Total
Acute	Indep	Sub	Indep	Sub	Unable	Indep	Indep	Indep	Unable	Indep	
	5	1	10	2	0	10	10	10	0	15	62
Local Authority	Unable	Unable	Indep	Sub	Unable	Sub	Indep	Indep	Unable	Sub	
	0	0	10	2	0	2	10	10	0	3	37
Differential	5	1	0	0	0	8	0	0	0	12	25

5.3.1.2. Occupational Therapists' Perceptions: Model of Human Occupation Screening Tool

The MoHOST assessment and outcome measurement tool was not universally regarded as having value across the Acute, Primary Care and Local Authority services. There was a clear division between Health based occupational therapy personnel, who without exception expressed reservations as to the efficacy of the MoHOST tool in practice; whilst their Local Authority contemporaries generally valued the tool and considered it efficacious in supporting practice and performance measurement.

The time required to complete the MoHOST tool was the predominant issue expressed by all the Health based Acute and Primary Care occupational therapists. The value in investing the time was undermined by a shared perspective that the tool did not resonate with the therapists' roles within these organisations. The consensus was that the MoHOST directed assessment practice into areas not routinely formally considered within traditional services e.g. patient motivation and role. These areas were considered as a superfluous administrative undertaking that did not inform the assessment process or the resulting service intervention (evidenced in table 8 and 9). The areas considered of value within the tool were restricted to the biomechanical elements such as mobility and transfers. The MoHOST tool encapsulates the person centred approach by considering, not only the biological and mechanical, but the psychological and social elements of a patient's presentation. This person centred approach arguably reflects the guiding ethos of the occupational therapy profession, which professes a holistic perspective to patient care. However, the practice emphasis toward the biomechanical elements within the Acute and Primary Care occupational therapy assessment and intervention activity prevailed. Unsurprisingly, the Health based occupational therapists, with the exception of one, did not perceive the tool to have influenced or affected practice in terms of reasoning or evidencing decision making. Therapists relayed concerns in respect to the tool's structure and language which was considered to be challenging and difficult for others within the health based multidisciplinary team to interpret. Accounts relayed by the staff group suggest the tool was frequently not completed as it interfered with existing documentation systems.

Although the challenges of the time required to complete and the tool's language were also identified by the Local Authority occupational therapy staff group, its utility was reported to improve as staff became more familiar with it through usage. The tool was considered to resonate with practice within the Local Authority context. Therapist accounts described the MoHOST as providing a structure to support reflective, evidence based practice which demonstrated and justified decision making. The value of this, within a political charged organisational context, was described as having particular value where professional decisions can be overturned in the absence of robust documentation structures that evidences

Chapter 5: Service Redesign -The Agency of Occupational Therapists professional reasoning. The therapists also indicated that the tool directly influenced their assessment and practice. The tool's focus on patient motivation and role was considered as being the catalyst for the change in approach. Therapists described a subtle shift from an assessment that focused on the physical functionality of the situation to one that considers the patient's aspirations within context. The only exception to this perspective was where therapists indicated the utility of the tool was reduced where the patients' needs were not complex. Questions were then raised as to the value of some of the fields e.g. motivation and role. The impact on intervention was perceived to be more limited as therapists indicated that the primary service intervention remained the provision of equipment and adaptations. Accounts of interventions within some of the interviews, however, suggested that interventions did alter as staff described assumed additional remits that would not have been the norm within traditional service arrangements e.g. mobility training/referral for reablement services as alternative to equipment. The Local Authority occupational therapists, who had experience of Acute based practice through the in-reach/outreach redesign measure, supported Notoh et al's (2013) reservations as to the utility of the MoHOST within a hospital ward context. The Local Authority occupational therapists similarly described the Acute ward based environment as not being conducive to obtaining the level of information required to complete the MoHOST tool. Concerns were also generally expressed that therapists may be making unjustified judgements about patients where the time with patients was limited.

5.3.1.3. Occupational Therapists' Perceptions: Single Shared I.T. Documentation System

The IT redesign measure was introduced to support the practice development approach and accommodated both the Modified Barthel Index and the MoHOST tools. The tools were embedded within the social work information system as a specialist module. Acute and Primary Care occupational therapy service personnel gained direct access to the specialist IT module facilitated by the multiagency store (IT data sharing exchange system between NHS Lanarkshire and South Lanarkshire Council Social Work Resources) This created the potential to standardise documentation structures and practices across Acute, Primary Care and Local Authority occupational therapy services. It also promoted continuity of care at an

Chapter 5: Service Redesign -The Agency of Occupational Therapists

informational level, as patient data could be collected and shared intra and inter-organisationally, with the capacity to elicit extended data in relation to the patient's formal and informal supports within the community.

All occupational therapy personnel, irrespective of employing organisation, expressed a resounding appreciation of the I.T. measure. However, the rationale for this appeared to be based principally on the concept rather than in the practical application of the system. Health subsidiaries utilised the I.T. system within the context of the redesign research site. Its application was limited to in-reach/outreach test cases (10 in Acute and 9 in Primary Care), which was a departure from the original plan that aimed to replace the traditional documentation structures in all cases. Reports from Health based occupational therapists illustrated that it did not replace their existing documentation arrangements even within the test cases. In effect, the introduction of the unified I.T. system generated duplicate activity within the 19 Health test cases. Therapists were reluctant to extricate themselves from the traditional documentation structures to embed the new I.T. system wholesale. The motivation for this appeared to be on the premise that the utility of the tools within the I.T. system (MBI and MoHOST) had not received validation from the extended multidisciplinary team. The value of the system to communicate the relevance and value of the occupational intervention was therefore called into question.

Furthermore, the MoHOST component of the I.T. system had been deemed by Health occupational therapists as an inappropriate practice approach as it did not resonate with the perceived role and purpose of service. This was despite the tool having been selected by representatives of the service pre service redesign as being one with potential utility in practice. Conversely, Local Authority occupational therapy service counterparts were familiar with the social work information system, albeit the specialist module incorporating the MBI and MoHOST tools was a new functionality within the system and created a revised documentation structure for the service. Previous documentation structures were discontinued entirely and the new structures were adopted by all Local Authority occupational therapy personnel in all cases, including personnel not participating within the service redesign research site.

Within these contexts, it was unsurprising that reports suggested that the data entry was sporadic and often incomplete within Health settings. The I.T. system's utility across all services appeared to be based on the therapist's ability to gather information relating to the patient's psychological status and their support network within the community e.g. family support, homecare etc. The occupational therapy specific IT entries were not utilised across the services and thence the system's capacity to promote data sharing was not actualised. Interview accounts indicated that the standard of recording varied across services and this was fundamentally attributed to differences in practice approaches and standards. In essence, Health colleagues were viewed by Local Authority occupational therapists as being risk adverse, and this was considered to be a potential barrier to joint working. The data entries, when completed, were considered to be circumscribed and impersonal, with an over-reliance on the tool's standard statements as opposed to generating narrative text to reflect the patient's specific personal circumstances. The system was predicated to follow the patient occupational therapy support pathway. This tended to originate from the Acute hospital phase to be transitioned into the community based Health Primary Care service and/or Local Authority services. As a consequence, Acute occupational therapists were not in a position to comment on the utility of their colleagues' entries within the I.T. system.

The utility of data sharing with colleagues from other disciplines was also the subject of reflection. Health based occupational therapists relayed concerns in respect to the tool's structure and language, which was considered to be challenging and difficult for others within the multidisciplinary team to interpret. Accounts relayed by the staff group suggest the tool was frequently not completed, as it interfered with existing documentation systems, which were considered to have more utility within the respective organisational structures. Again, in contrast with Health based colleagues' experience, the Local Authority occupational therapists referenced the positive utility of the tool in sharing patient information with other organisational colleagues from other disciplines; namely social workers. However, there was recognition that its utility could be improved if the presentation of information were further developed. It was acknowledged that the MoHOST tool did not lend itself to *sound bite* data that reported on the impact of interventions in a condensed format for ease of reference or interpretation. This observation perhaps lies at the core of

the different perspectives expressed by Health and Local Authority occupational therapists as to the tool's utility in sharing patient information with multidisciplinary colleagues. Health based therapists commented on medical consultants not valuing the data generated by the tool and it not being as user friendly as the physiotherapy outcome measure, which is reported to be numerically based without a narrative component. Local Authority social work colleagues expressed a value in the MoHOST assessment in providing invaluable data to inform their respective engagement with patients.

Furthermore, as was emphasised in the response of one of the Local Authority occupational therapists interviewed, the MoHOST tool was viewed as being a mainstay within service, because it was a project implemented directly by the service manager. The status and value of the tool within the Local Authority context was effectively established and validated within the organisation. The respective occupational therapists' view and application of the MoHOST tool appears to be influenced by the organisational context in which they operate and the political, managerial or medical masters they are accountable to. The disconnect between the respective services' approach to practice and documentation created tensions and mistrust between services. Therapists described experiences where questions were routinely raised about their colleague's assessments and interventions. The ramification of this position questions the utility of data sharing between services and profoundly undermines the concept of shared assessments, even within the same professional discipline.

5.3.1.4. Occupational Therapists' Perceptions: Introduction of Service Coordinator

The therapists' reaction to the introduction of the management measure was illuminating. The introduction of a single service coordinator who had delegated responsibility in the identification, allocation, supervision and closure of cases across the Acute, Primary Care and Local Authority services created a parallel management structure for all services. The differential lay in the fact that Acute service personnel were, within traditional service arrangements, autonomous in caseload management from the identification to the discharge of patients within service. Primary care and Local Authority occupational therapy personnel were

Chapter 5: Service Redesign -The Agency of Occupational Therapists
familiar with line management allocation and closure processes. All were familiar with line management supervision structures.

The interview responses presented the Acute occupational therapy experience of the management measure as one of bewilderment, uncertainty and pressure. Descriptions reflected unease with the coordinator knowing of patients before they did (utilising the social work information system). There also appeared to be a self-inflicted pressure to identify patients for community rehabilitation. This resulted in modified behaviours, which were consciously acknowledged by the Acute therapists. The behaviours contrived to continue to see the patient when they were not ready for rehabilitation. Additional pressures were created from the perception that ward staff had expectations arising from the traditional operational arrangements e.g. occupational therapist visibility on the ward. The intensity of these pressures was magnified and compounded with a vehement objection to having supervision where the occupational therapist's clinical reasoning was questioned. Despite being familiar with line management supervisory arrangements, the nature of questioning within the new arrangement context was unfamiliar and unacceptable. The sensitivities within the staff group were such that experienced/senior practitioners were reported to demonstrate their level of frustration through unprofessional physical manifestations e.g. kicking doors. The appointed coordinator, who challenged practice, was not accepted as an authority figure and a formal complaint and counter complaint were submitted.

The Primary Care occupational therapy staff experience was contained to a sense of pressure and self-doubt. The groups' concerns centred on their capacity to fulfil the traditional role expectations, whilst assuming the extended responsibilities within the redesigned service. There was a consensus that these pressures were largely self-inflicted, but were within the context that the traditional service performance measures focussed on numbers of patients seen within a calendar month. Any time committed to assuming the extended role and functions within the service redesign approach detracted capacity to honour the anticipated volume of patients registered within the traditional service statistical returns. The ability to respond to the service's established waiting list was also a consideration. The Primary Care occupational therapy personnel originally also questioned the need for their clinical reasoning to

Chapter 5: Service Redesign -The Agency of Occupational Therapists

be questioned. They also initially queried the value of the buddy system in operation. However, in-practice experience changed their perspective and the support from the coordinator and buddying arrangement was not only appreciated but actively sought to promote development and ensure standards expected were being achieved. The management measure was ultimately recognised as part of the infrastructure to support the change process and was utilised to rationalise and negotiate numbers of test cases to be undertaken and to clarify the expectations within the change programme.

The Local Authority occupational therapists' experience of the management measure was summarised as pressured and awkward. The permission granted to afford additional time to test cases was considered to be an unrealistic luxury, as it was felt to be at the cost of other casework within their workload, where the same luxury was not afforded. The reality imposed by the service performance indicator to be assessed within 28 days, created a perceived pressure and tension about awarding additional time within the test case arrangements. The awkwardness experienced by the staff group was reported from two distinct perspectives. The first related to the absence of a unified approach between the Team Leader with line management responsibilities for the team members and the appointed coordinator with delegated management responsibilities under the auspices of the service redesign implementation. The tension arose as therapists sought to secure permissions for activity from both managers in order that diplomatic relations were maintained. Despite this, the therapists indicated they felt well supported and particularly appreciated the intelligent allocation of work to ensure that workloads remained manageable. These sensitivities were also experienced by the Local Authority therapists during the buddying arrangements with Health colleagues. The sentiment expressed was sensitivities in encroaching on colleagues' work roles. The inference was there was a public face that therapists abided by in the implementation of the operational arrangements which masked the reality of the relations. These relations were superficially respectful, but fundamentally the relations were coloured with professional concern about practice at best, and alarm at worst.

5.3.1.5. Occupational Therapists' Perceptions: In-reach/Outreach Practice Arrangements

The culmination of the three interrelated service redesign measures i.e. MBI /MoHOST practice approach , I.T. development and management infrastructure created the potential capacity to facilitate in-reach/outreach occupational therapy practices that promoted patient continuity of care at a management and relational level. The empirical and experiential reality of the in-reach/outreach test cases, however, illustrates that the aspirations of the service redesign were not realised in totality. Occupational therapists from Acute, Primary Care and Local Authority settings all described a sense of being out of their comfort zones, which generated operational uncertainty in practice. Some contributing factors related to professional and personal skill set limitations in undertaking the extended roles demanded by the in-reach/outreach patient management approach; whilst other factors related to environmental, management and technical issues.

Therapists within Acute, considered themselves to be in the strongest position to undertake the extended role, this perspective being borne from what some considered to be a firm experience base within the Acute setting which transcended the rehabilitative and discharge coordination dimension, inclusive of the community element (through environmental assessments). However, reports from management would suggest that staff stress levels were high during this period of service change. Service accounts indicate that there were complaints on a daily basis, with aggressive physical manifestations reflecting the degree of frustration for some service personnel. Job descriptions were being presented to management and staff were threatening to withdraw from the project and/or go to Human Resources and the Unions to object to the expectation being requested within the service redesign. Accounts indicate that significant levels of management investment were focussed on conflict management to safeguard the investment in the change programme. The pace of change and the fact that the service redesign was required to deliver from within resources, with no backfill provision, was considered to be an additional pressure that did not take account of the current commitments and responsibilities of the service. Within this service context, it was unsurprising that the buddying system was not considered to be sufficient to support staff to assume the extended role in complex cases by the Acute occupational therapists.

Acute based occupational therapists retained a public face within the interviews and did not divulge the extent of the difficulties experienced by the staff group. However, what was reaffirmed during the interviews were instances of unjustified practice behaviours arising from uncertainty e.g. continuation of therapeutic intervention when the therapist had determined it was not required and this had been approved by line management. No specific explanation was offered, but may have arisen from similar service tensions experienced by Primary Care health colleagues within the new operational context of the redesigned service.

Primary Care occupational therapists referred to a tension in what was classified as downtime within what was traditionally the Local Authority element of the patient care pathway. The downtime was generated when the occupational therapist's direct involvement with the patient was suspended whilst another service, such as an architect or contractor, undertook the element of work required. The case was neither closed nor active, but the duty of care remained as the therapist would resume active involvement once the parallel service had completed the commissioned work. The tension arose as Primary Care therapists were required to absorb and redirect their resource capacity to new patients, whilst maintaining care management responsibilities for existing patients. This required therapists to simultaneously initiate new casework and honour existing responsibilities by coordinating parallel processes delivered by other services over which they had no direct control. This was not the practice norm within traditional service arrangements, where Health Acute and Primary Care occupational therapy services' patient duty of care responsibilities only extended to the period where occupational therapy services were actively involved. The advanced level of technical expertise within the Local Authority occupational therapy service was also acknowledged by Primary Care colleagues, who were in awe of their counterparts' ability to multi task and manage multiple patients within their caseloads. Primary Care occupational therapists' reflections on this were that it would require a specific type of therapist to undertake the role.

Furthermore, related comments from certain Primary Care representatives suggested that the extended duty of care role would not be of specific interest, unless it facilitated components of the primary care role. Those who were inspired

Chapter 5: Service Redesign -The Agency of Occupational Therapists

by the experience to further develop the extended duty of care responsibilities appeared to be motivated by professional self-interest and qualified their interest to areas that would not require lengthy processes or involvement. Examples considered as too protracted to consider under the auspices of primary care included interventions that would be considered by Local Authority colleagues as mainstream e.g. shower adaptations.

The Primary Care occupational therapy role was defined as more linear, with a focus on throughput and “doing to” patients rather than the coproduction approach witnessed within Local Authority services. The general consensus from Primary Care service occupational therapists was that they did not feel confident in assuming the extended duty of care responsibilities required to undertake the in-reach/outreach model of care within the service redesign. This was reflected in the number of incomplete test cases (6/9) and the self-acknowledged reliance on the buddying arrangement with Local Authority occupational therapists to complete the elements that were undertaken under the auspices of the Local Authority component of the patient pathway. Primary Care occupational therapists also described infringements on their practice comfort zones arising from specific system related changes. These included inexperience with the IT documentation system, the challenges of the language in the MOHOST tool and its application in practice and the unfamiliarity in the organisational systems within the Local Authority setting. There was also a sense that the expectation to absorb the additional remits associated with the extended duty of care was unrealistic. The increased length of stay in service arising from the extended duty of care was reported to detrimentally impact on patient turnover and service statistics. Further operational implications arising from an inability to honour commitments within traditional service arrangements were also outlined as problematic e.g. delays in completing patients’ summaries for GPs. Comments from Primary Care suggesting that they had not benefited from the whole system reconfiguration of services, where patients were redirected to other services to be managed through the entire care pathway, illustrated a service introspective perspective that was not altered with empirical evidence to the contrary. This position was apparently held by the practitioner(s) because they personally did not perceive a reduction in workload.

The Local Authority occupational therapy services' reflections on the inreach/outreach experience suggested that therapists were relatively confident in undertaking the extended role in practice with minor adjustments. The change process and timeframe for implementation was initially considered to be daunting, but operational experience in the implementation, coupled with the support infrastructures, resulted in staff feeling less concern as their role was not considered to have changed significantly. Therapists indicated that they were inspired by the new opportunities created by the redesigned service and had witnessed a positive impact on patient care by reducing levels of dependency on equipment and adaptations and other social care supports such as homecare.

Reports suggested that the buddying arrangements were not required and sufficient supports were obtained from the management infrastructure. The test cases described were perceived as uncomplicated and relatively easily absorbed within caseloads. Some therapists reflected that any additional visits were in hindsight not considered as necessary and undertaken within the test cases to compensate for staff's initial uncertainty in the extended duty of care elements of their role. Others considered that the test cases did indeed warrant additional direct and indirect contact and as such would have implications on the organisational performance measure. (28 day assessment standard).The purported professional adjustments related to the challenge of having to consciously detach from the equipment and adaptations focus within service to consider rehabilitation/reablement as the most appropriate intervention where indicated. The challenge, even within the equipment and adaptation field, was in resurrecting dormant skills and moving from providing advice in the use of the equipment to that of practical demonstration and application. The areas where the Local Authority occupational therapists experienced a degree of professional disquiet primarily related to processes and procedures within other service sectors e.g. use of ward based hospital equipment such as the hospital bed and unfamiliar clinical procedures such as catheter care and soap note entries (ward based documentation). Indeed, the clinical environment generally was reported to create a level of discomfort in practice, as it did not resonate with the actual environment the patients were discharged to. This environmental consideration was raised within both the Local Authority and Primary occupational therapy staff groups and the validity of the interventions within the Acute ward setting was questioned.

Questioning current whole system occupational therapy service arrangements was a central theme within the Local Authority service interviews, some of which was also reflected within Primary Care service interviews. The in-reach/outreach practice arrangements, with the associated buddying arrangements, created scenarios for therapists from discrete services to visit and experience other occupational therapy services in practice. Therapists observed and recounted significant service variation in professional practice across services. The identified differences were multiple and interrelated. This included fundamental differences in the type of patients being identified for occupational therapy interventions within services. The differences experienced by the therapists were reflected within the empirical evidence where patient dependency levels were shown to be significantly different across the discrete services. The professional decision making and judgements within interventions were also open to peer scrutiny. The speed of, and the parameters to inform, the occupational therapy decision making within Acute services was queried by peers. The process was considered to be primarily based on the physical abilities of the patient and the physical environment, without due consideration of the extended social and psychological dimensions. This assessment methodology was not considered to be conducive to person centred approaches to care and did not accommodate the ability to embed alternative intervention approaches that improved outcomes for the patient. Measures to compensate for assessments devoid of essential detail may predispose the risk adverse practices by Health colleagues previously cited by Local Authority occupational therapists. The patient's capacity and potential to manage risk effectively in their own social circumstances would not be given due consideration within the assessment process; effectively creating unnecessary demands for support services and ironically, within a service aiming to promote independence, potentially generating patient dependencies.

Communication arrangements and approach within Acute, Primary Care and Local Authority services were perceived by the Local Authority occupational therapists as compounding the differences in the management of patient care. Case examples from both the Acute and Primary Care settings indicated that the level of information sharing within the buddying arrangement was inadequate. The inadequacy recounted through case example suggested that it can be at a level that compromises the patient's clinical wellbeing. Therapists also described limitations in

Chapter 5: Service Redesign -The Agency of Occupational Therapists

appropriate levels of information sharing within the multidisciplinary context and indicated that there was a reliance on patients' accounts to provide an update on progress.

Furthermore, communication with patients and carers within health based occupational therapy services was noted by Local Authority occupational therapists as being restricted, with detrimental results in the management of patient care. Patients were reported to become disengaged from the occupational therapy intervention process and carers became disillusioned and felt unsupported. The in-reach/outreach practice experience prompted therapists to acknowledge the differences in professional opinions and practice within the discrete services. Despite this, a heightened awareness of professional protectionism within the context of the service redesign and a period of uncertainty within staff groups resulted in therapists refraining from openly questioning or challenging peers. Therapists conveyed sentiments of not wishing to undermine colleagues when visiting "foreign turf" and described situations where they found themselves responding to their colleagues' agenda, despite reservations.

Concerns were expressed as to the aftermath of the service redesign and the impact on inter-service relations arising from this knowledge. Therapists were conscious of a potential perception by health colleagues that the service redesign was being driven from a Local Authority perspective with an underlying objective to transform health based services by imposing Local Authority based approaches; effectively turning health based staff into Local Authority practitioners. Reflections by Local Authority occupational therapists also generated questions about their own practice. The appropriateness of services curtailed to equipment and adaptations in achieving optimum outcomes for patients were recognised to be limited. The Local Authority occupational therapists also acknowledged that their assessment parameters were essentially circumscribed to predetermined activities of daily living. This was largely directed by the range of equipment/adaptation resources available to the service that could maintain or support independence or the caring situation and effectively precluded extended activities of daily living that would require alternative more time consuming interventions e.g. rehabilitation/reablement.

5.4. Service Redesign: Perceived Impact on Continuity of Care

Therapists were specifically asked to reflect on the experience of the service redesign and consider any benefits arising from changes introduced via the redesign mechanisms to patients, the service and/or the profession. The therapists' responses were subject to content analysis and are presented under the "Informational", "Management" and "Relational" continuity of care categories. Continuity of care for patients was almost universally identified as being a product of the service redesign by the occupational therapists within each of the occupational therapy services. 12 of the 13 therapists (92%) articulated some benefits to the patient experience arising from improvements in continuity of care at all levels, though the level of enthusiasm and commitment to these identified benefits was variable.

5.4.1. Service Redesign: Perceived Impact on Continuity of Care at a Relational Level

The most significant impact identified by the occupational therapists interviewed related to relational continuity of care for patients, with 10 of the 13 therapists (77%, 2 Acute, 3 Primary Care and 5 Local Authority) indicating tangible benefits for the patient and carers. This was primarily attributed to the extended length of contact with the patient arising from the redesign measures that facilitated the in-reach /outreach practice arrangements. Therapists across all three service sectors described an ostensible shift in the patient/therapist relationship. Therapists described a reduction in patient and/or carer anxiety engendering an increased level of communication and engagement. Patients and their carers were described as being "empowered" to express their preferences, and therapists intimated a palpable recalibration of the power balance in favour of the service recipient. The following extracts from an interview transcript illustrate the experienced practice shift on an Acute based occupational therapist and the impact on the patient in receipt of the service.

COE 2. "Although the test cases I was involved in didn't improve (patient's functional ability), the basis of assessment was different (within the patient's home as opposed to the hospital setting)...the patient and family could relax and the power balance was in their favour... I was a guest "

COE 2. “In the patient with a stairlift (outreach test case)... the patient indicated he did not need a stairlift and he proved the OT and physio right”

These reflections would appear to provide a powerful and positive endorsement of the service redesign on achieving the benefits of relational continuity of care. The patient was in the position of authority and was empowered to influence and make appropriate choices about his care. However, this therapist prefaced these statements with a proclamation that the redesigned approach to practice did not have any tangible benefits in respect to patient continuity of care. The rationale for this statement was that patients, on certain occasions, did not recognise her from the hospital setting. This contradictory response was not unique and reservations such as this were reflected by another 2 health based therapists, both of whom subsequently acknowledged continuity of care outcomes for the patients in their care. Relational continuity of care was also deemed as having had a significant impact on the therapist's professional perspective, as 6 of the 13 therapists (46% Acute, Primary Care and Local Authority) described being afforded the time to engage with the patient and becoming more involved with extended elements of patient care. The therapists indicated an improved insight as to the patient's motivations and what was important to them, describing a more personal and enhanced therapeutic rapport with their patients and/or carers as a consequence. These therapists acknowledged that the interventions within the patient's home setting were advantageous as the patient's presentation and compliance with the intervention was enhanced. This perception however, was not universal. Two Acute based occupational therapists' views suggested that patients were less able in the home environment and interventions had more purpose in the hospital setting.

5.4.2. Service Redesign: Perceived Impact on Continuity of Care at a Management Level

Patient continuity of care at a management level was also significant as 8 of the 13 therapists (62% Acute, Primary Care and Local Authority) acknowledged a positive effect on how the patient experienced their service across the traditional service boundaries. The therapists did not perceive the change as being attributed to occupational therapy practice shifts per se, but appeared to interpret it as a

consequence of a single therapist assuming the extended duty of patient care through the Acute, Primary Care and Local Authority elements of the care pathway. The effect of this was acknowledged as being an extended length of patient stay within service, which was perceived as creating the potential to deliver more appropriate interventions, more timeously and with fewer incidences of duplication for the patient. Despite the therapists' apparent non-acknowledgement of changes in their professional behaviour, the therapists' accounts during the semi structured interviews arguably illustrated some tangible practice adjustments. These included reports of assuming extended roles e.g. Acute based personnel investing in not only advising, but teaching patients and carers in the use of the equipment and/or adaptations provided; Local Authority occupational therapists utilising dormant skills in delivering graded rehabilitative activities not normally addressed within service; and all therapists working collaboratively with other allied health professions and Local Authority Homecare reablement service personnel in efforts to avoid traditional modes of intervention which were deemed to create unnecessary dependencies. Professional satisfaction was reportedly derived from being engaged with the patient from the inception of the occupational therapy service journey to its conclusion. The level of professional satisfaction reported was striking, with 10 of the 13 (77%) therapists reporting increased levels of professional fulfilment within the redesigned service arrangements. In effect, the redesigned service was considered by those who responded favourably as having the potential to provide a longitudinal person centred practice approach that served to address the boundaries and limitations imposed by the silo operational arrangements within traditional service structures.

Contrary to these positive assertions about the experienced impact of the service redesign measures on patient continuity of care at a management level, the therapists also shared less favourable perceptions. These reaffirmed the discomfort therapists were experiencing with the extended duty of care responsibilities associated with the in-reach/outreach practice arrangement. The unease was generated from a competing tension between what was perceived as a benefit to the profession vis a vis a benefit to the patient. Therapists who expressed their perceptions of the impact of the service redesign on continuity of care as limited

Chapter 5: Service Redesign -The Agency of Occupational Therapists appear to have measured the success in terms of their capacity to engage in perceived professional pre-existing professional roles.

COE 1. "Overall they weren't successful (in reference to outreach test cases within patients' homes)...1 patient died, and the other 2 did not really need ongoing rehab...the transfer and kitchen practice wasn't really of any benefit"

Comments that indicated perceived limited success because patients within the test cases did not present with rehabilitation needs suggest an overriding professional entrenched position, perpetuating outdated service driven models of care that are devoid of personalised outcome focussed approaches to service delivery.

5.4.3. Service Redesign: Perceived Impact on Continuity of Care at an Informational Level.

Informational continuity of care was perceived to be the least developed strand of the three levels of patient continuity of care. Only 4 of the 13 therapists (31%) acknowledged any beneficial impact from a patient's or professional /service perspective. The impact identified related exclusively to the relaying of information between the patient and therapist and vice versa. Again, this was attributed to the longitudinal approach to care and the therapeutic relationship fostered that promoted the engagement and augmented exchange of information between therapist and patient and/or carers. As a result the knowledge about the patient was accumulated over a period of time and at different stages of the care pathway. This was reported to effectively create a professional confidence within the occupational therapy staff group who felt better informed to take appropriate interventions on behalf of the patient.

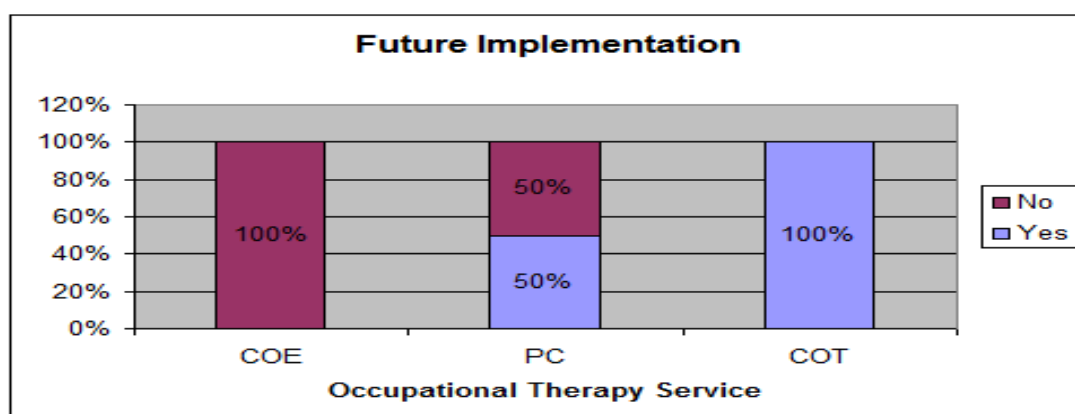
Unsurprisingly information sharing between Acute, Primary Care and Local Authority services was not considered to have changed. In effect, extending the duty of care to a single therapist through the in-reach/outreach redesign measure removed the need to transition patients between services. As a consequence, the need to relay patient information from one occupational therapy service to another was removed. The exception arose within the incomplete test case scenarios, where 8 Acute and Primary Care incomplete test cases were transferred to the Local Authority service

Chapter 5: Service Redesign -The Agency of Occupational Therapists for completion. The information relayed within these cases was reported to be missing, incomplete or misleading.

5.5. Service Redesign: Occupational Therapists' Perspectives on Full Implementation.

The penultimate question posed within the semi structured interview encapsulated the therapist's individual and collective perspectives in respect to the service redesign measures. Therapists were asked whether they would wish to pursue the full implementation of the service redesign and embed the service redesign measures within mainstream Acute, Primary Care and Local Authority older people services. The results of this question posed to the therapists are illustrated in Graph 13.

Graph 13: Occupational Therapists' Perceptions on the Full Implementation of the Service Redesign



The results presented a whole system workforce that was equally divided in their views in respect to the further development and implementation of the service redesign. However, the interview discourse illustrated that the sentiments behind the blatant “yes”/ “no” replies concealed the spectrum of attitudes and views held by the occupational therapists and demonstrated a continuum of nuances within the occupational therapists' perspectives that determined the final response asserted. Acute occupational therapy personnel acknowledged that from a patient perspective the tested redesigned service would improve current service delivery in terms of patient continuity of care. Despite this, the Acute based occupational therapists universally rejected the future implementation of the service redesign. The rationale

Chapter 5: Service Redesign -The Agency of Occupational Therapists offered from a practitioner perspective indicated that the redesign was too challenging on a personal basis for both practitioner and management tiers. The demands related to not being part of a single multidisciplinary team and being required to engage with multiple personnel from different organisational structures. The practicalities of managing the change were also highlighted as a prohibitive factor in the further implementation of the service redesign. References to the extreme personnel issues experienced during and within the service redesign test site (occupational therapists' behaviours) were cited as a significant limitation in realising the service redesign across the whole system. The context in which the implementation of the service redesign could potentially be realised was considered to be dependent on the implementation of the change within the extended multidisciplinary team. Ultimately the Acute occupational therapy staff group's perspective on the service redesign experience was summarised by one therapist as...

COE 1. "I like the concept, but not the reality".

All therapists within the Primary Care service only experienced the extended duty of care within the Local Authority service and singularly did not venture in the Acute element of the patient pathway. The Primary Care occupational therapists were divided in their expressed volition to further develop the service redesign model within service. However, the divergent perspectives are diluted as the rationale provided by those who indicated their preference with a "no" mirrors the provisos stipulated by those who responded with a "yes". Irrespective of whether therapists intimated their preference with a "yes" or "no" to the question posed, all therapists contextualised the answers with a rationale or a proviso that were ultimately interchangeable. The collective responses reaffirmed the therapists' reluctance to assume an extended role beyond that that interfered with their current *modus operandi* within service. The assumption of any additional extended duties would have to be in the context of comfortable parameters and not involve additional responsibilities. There appeared to be a general acceptance that tasks that were not onerous or time consuming e.g. organising stairlift provision were appropriate; but those tasks that involved extended periods of patient length of stay in service e.g. shower installation or major adaptations were not considered as appropriate. The

Chapter 5: Service Redesign -The Agency of Occupational Therapists

volume of documentation experienced within the Local Authority setting was also considered to be prohibitive due to the amount of time required to complete.

The variation in responding in the affirmative or negative to the question by the Primary Care occupational therapists appears to be based on the respective therapist's personal construal of the potential impact of the additional duties on the current primary care occupational therapy service arrangements. Any activities considered to extend the service practice and system parameters beyond the therapists' perspective of what was considered acceptable were dismissed as infeasible. The governing determinant was preserving the stability of the existing service arrangements without due consideration as to developing intra and inter service arrangements that delivered improvements in patient care and organisational service efficacies.

The Local Authority occupational therapy responses indicated a resounding positive response to the direct question as to whether they would wish to continue implementing the practice and system related measures within the service redesign. However, all local authority therapists also qualified their responses with statements that contextualised their position in relation to the matter. One of the therapists intimated that this service redesign was a "fait accompli" as it was predestined by the service manager to be implemented. The suggestion was that there was no option but to comply with the redesign approach, as management had dictated the terms of engagement within the service redesign. This was, in part, light hearted banter, as the therapist expressing this sentiment was relaying it to the interviewer who was also the service manager in question. However, the management influence on driving some of the redesign developments was duly acknowledged.

A further two therapists intimated that although they were committed to the implementation of the service redesign in principle, their reservations were attributed to the time pressures associated with the existing 28 day assessment service standard and the completion of the MoHOST tool. The professed proviso in this instance was that the pre-existing 28 day service standard would require to be revised and the MoHOST tool would require to be refined in order that the language and structure be simplified for mainstream implementation.

All six participating occupational therapists individually qualified their position by stating that the developments should focus on shifting the balance of care into the community setting. The emphasis was clearly on developing the community rehabilitation element of the service, traditionally attributed to the Primary Care service and the equipment and adaptation service, traditionally associated with the Local Authority occupational therapy service. The synergy between the community based Primary Care and Local Authority services was recognised as natural continuum in terms of patient care. However, all Local Authority occupational therapists who in-reached into the Acute setting as part fulfilment of the test case activity (5)⁵⁵ questioned the validity of the occupational therapy input within the Acute phase of the patient care pathway. The prevailing medical model within the Acute hospital setting was viewed by the Local Authority occupational therapists as promoting a reductionist practice approach by the Acute occupational therapists. This approach was considered to be lacking in acknowledging the extended social dimension of patient care to the detriment of the value of the service to the patient. The status of the Acute multidisciplinary structures within the organisational context was considered to be seminal in shaping the Acute occupational therapy colleagues' approach to patient care and limiting the service's capacity for change. The current Acute occupational therapy service allegiance to the existing medical multidisciplinary structures was perceived by their local authority colleagues as a potential barrier to the implementation and further development of the service redesign.

Despite the service redesign being recognised as having the potential to improve joint working between services, the Local Authority occupational therapists suggest that their in practice experience would indicate that joint working had taken a retrograde step. It was noted that their Acute colleagues undertook the majority of the extended duty of care functions (within the auspices of the in-reach/outreach redesign measure), within the confines of the Acute hospital base. The reported observations suggested that Acute colleagues actively resisted shifting the balance of care from the Acute to the community setting. Equally, the Local Authority

⁵⁵ Service Team Leader did not engage in the in-reach/out-reach practice redesign measure implemented.

Chapter 5: Service Redesign -The Agency of Occupational Therapists

therapists considered the time invested in delivering occupational therapy services within the Acute setting, within the context of their in-reach activity, was considered to be negligible and not worth the effort.

5.5.1. Service Redesign: Summary of Perceptions

In general terms, the occupational therapists relayed advantages in assuming extended roles, but this was in the main, limited to further understand the roles of colleagues within different organisational contexts. These accounts largely described learning about differences in organisational processes and systems, which was felt to be of value in order that more appropriate communications between services could be affected. Very few positive comments were made in respect to the actual role and remit assumed by other discrete occupational therapy service colleagues. The majority of professionally related disclosures, although carefully constructed in order not to undermine their colleague's integrity, challenged discrete service practices. The Acute service personnel were considered to be risk adverse and entrenched in traditional clinical models of care that created unnecessary patient dependencies; whilst Primary Care services were perceived as not fulfilling their rehabilitation role; and Local Authority occupational therapy services were considered to be unrealistic in the extended interventions they assumed within the redesigned service context e.g. focussing on patients' activities of dressing/self-care in clinical setting, when practice norm would suggest this was not a service priority in the Acute context.

The subtleties of what was being described reflected a fundamental difference in professional and organisational practice that was not necessarily consciously acknowledged as an intrinsic barrier to achieving patient continuity of care at an informational, management and relational level. Although practice differences were acknowledged, and in instances commended, the therapists' pre-existing value bases were entrenched and restricted service and professional development. This was evidenced in the circumscribed nature and mode of current service delivery. The implications of this situational context on the service redesign developments emerged from the empirical evidence and the reported perceptions of the occupational therapists on the experience of the introduction of the four key redesign measures.

Chapter 6: Mechanism Based Theorising and Discussion

6.1. Introduction

This critical realist research deployed two intertwined activities in the evaluation of an occupational therapy service redesign which aimed to minimise the incidence of patient transitions of care across Acute, Primary Care and Local Authority occupational therapy services.

Firstly a description of the empirical findings and events as presented in chapter 4 provides an overview of the events at the actual level. These results suggest a degree of success in realising the service redesign objective of minimising the incidence of patient transitions of care through the reduction of the average number of therapists engaged in a patient's single episode of care from 2.3 to 1.5 therapists. This data however also simultaneously highlights service specific variations in the execution of the continuity of care measures introduced to achieve this objective across the Acute, Primary Care and Local Authority services. Differences in the therapists' capacity to assume the extended remits enacted through the introduction of the continuity of patient care service redesign measures were demonstrated. Furthermore, the quantitative data presented in chapter 4 served to illustrate service specific incongruities in practice that raised questions as to the efficacy of the occupational therapy service in delivering person centred care across the occupational therapy care continuum.

Secondly, chapter 5 presents qualitative data that begins to explore the therapist's underlying cognitive reasoning, volition and motivations that potentially generated the observable tendencies reflected in chapter 4. The results reveal varying structural influences and agentic perspectives on the pre and post service redesign practice arrangements. This chapter (chapter 6) revisits the quantitative and qualitative research findings and re-describes the observable tendencies in an abstract sense in order to describe the sequence of causation that gives rise to observed regularities in the pattern of events. It involves combining observations from both chapters 4 and 5, in tandem with theory identified in the literature review, to produce the most plausible explanation of the structural and agential mechanisms that caused the service specific events that ultimately culminated in the service redesign outcomes.

The research findings in both chapter 4 and chapter 5 present results that are discernibly contingent on the specific occupational therapy service context from which they are employed. The temporally stratified nature of the identified situational⁵⁶, action-formation⁵⁷ and transformational mechanisms⁵⁸ (Hedstrom and Swedberg 1998) support the structure of this chapter, and theories are postulated as to the causal powers and potentials of these mechanisms in the implementation of the service redesign measures. This three-part change process of Hedstrom and Swedburg (1998), based on the work of Coleman (1986), is consistent with the morphogenetic cycle of Archer (1995), which describes how existing structural conditions predate social interaction, which in turn leads to structural elaboration or reproduction.

6.2. Situational Mechanism Based Theorising: Macro to Micro Level

Situational mechanisms operate at the macro-to-micro level. This type of mechanism explains the influence of macro forces on micro level phenomena. The subject of this critical realist evaluation research is a service redesign change programme that is fashioned by successive central governments' political strategic plan to address the problematic demographic social phenomenon and the associated fiscal challenge facing the UK. Legislative and policy drivers since the 1990's have systematically and incrementally mandated health and social care partnership working and integration as a means to affect major policy and practice level changes within public services in order to meet the nation's challenges. The Joint Future Group's strategy (2000) positioned occupational therapy services as central to the government's public service modernisation programme. This strategy incorporated the Third Way's sociological ideology of measures to reduce the avoidable economic burden on society by capitalising on the public's inherent capacity to be independent from state support on an individual and collective basis. The directive by central government was, and continues to be, the development of collaborative and coordinated health and social care systems within health and

⁵⁶ Situational mechanisms operate at the macro-to-micro level. This type of mechanism explains the influence of macro forces on micro level phenomena

⁵⁷ Action-formation mechanisms operate at the micro-to-micro level. This type of mechanism links individual cognition to behaviour

⁵⁸ Transformational mechanisms operate at the micro-to-macro level and show how individuals, through their actions and interactions, generate macro-level outcomes (Hedstrom and Swedberg 1998)

social care partnership arrangements at a local level. The emphasis is on shifting the balance of care from the acute institutional setting to a community based service model that promotes person centred care. The promotion of patient independence and supporting informal support arrangements out with public services was conceptualised as the measures to realise the reduction of patient dependence from state support.

This contextual descriptive summary of macro level forces forms part of the institutional abstraction of potential mechanisms operating within the structure of activities at a meso-service level and at a micro-agential level. The specific powers and mechanistic potentials of the central government directives on partnership working, which have transcended nearly three decades, were not overtly evident within the occupational therapy pre-service redesign baseline data. Occupational therapy service structures retained and operated within their employing body's traditional organisational constructs. Each service preserved their hierarchal structures, professional roles and practice locations, lines of accountability, service systems and priorities. Limited evidence was available to indicate that the central government mandated strategic partnership developments penetrated occupational therapy service operational arrangements within Acute, Primary Care⁵⁹ or Local Authority services. Indeed, the time and motion and retrospective case record analysis (Tables 2-5) indicated that the occupational therapy service activity remained largely within the auspices of the employing body's organisational structures. The emphasis within all three services was on intra rather than inter-organisational working.

Ironically, the service inefficiencies generated from the rework activity as patients transitioned through the occupational therapy services within a single care episode (as detailed in the service activity analysis detailed in chapter 4), could be as a consequence of the unobservable causal entity of central government's governance infrastructures. Each therapist recounted their primary role and function to reflect the nuance of their respective organisational priorities (Graph 5) and the espoused service drivers were aligned to the service standards and performance measures

⁵⁹ The establishment of the Primary Care Early Supported Discharge Team structures is acknowledged as having been introduced as part fulfilment of the Shifting the Balance of Care (1997) agenda.

specific to the employing organisation (Graph 4). The input/output mode of performance measurement introduced in 2003/04 through the Joint Performance Information and Assessment Framework (JPIAF) continued to be the prevailing mode of measuring performance within the occupational therapy services. The synecdoche nature of these quantitatively based performance measures, which did not account for the interconnectivity of intra-organisational performance measures had, as Wheeler (2003) and De Bruijn (2007) envisaged, resulted in waste being driven into the system.

Duplicate and triplicate assessments were observed as being the inter-organisational practice norms, with instances of individual patients experiencing up to five assessments by different occupational therapists within a single care episode. This, combined with the associated time dedicated to the related preliminary information gathering activity and the subsequent activity of documentation within the Acute, Primary Care and Local Authority occupational therapy services, suggests that the services were not working collaboratively and targeting their resources efficaciously. Paradoxically, these intra-organisational practice arrangements, as described by Corrigan (2001), where staff curtail practice to within the auspices of the organisational parameters of the employing body, result in patient transitions of care. Continuity of care at an informational, management and relational level is, as a result compromised. In effect, the central government performance measures designed to expedite partnership working appears to have activated underlying generative mechanisms that have resulted in the perverse consequence of promoting the service outcome they sought to minimise i.e. uncoordinated patient care. Additionally, this intra-service *modus operandi* contravenes the strategic ambitions of central government to contain costs within health and social care services.

In the pursuit of achieving the predetermined intra-organisational targets, the occupational therapists may also have engaged in gaming activity as described by Bevan and Hood (2006). For example, the observable tendencies within certain occupational therapy services demonstrated patients with no or low level dependencies being selected for occupational therapy intervention in place of patients with greater dependencies (Graphs 1 and 2). Although conceivable that the professional intent of this practice was to maintain levels of independence, a critical

realist counterfactual explanation supports the theory that the primary motivation was to service the performance measure requirements that seek to evidence service patient throughput as opposed to service patient outcomes. If this is indeed the case, the occupational therapists' expertise and judgment about what was in the best interests of their patients would appear to have been deferred in favour of action that sought to achieve the pre-set targets.

The pursuit of performance targets that encourages compromising and evasive behaviours creates a practice, performance paradox. This phenomenon, as highlighted by Meyer and Gupta (1994) and Meyer and O'Shaughnessy (1993) was also detected within the observable tendencies that suggest occupational therapy service assessment and intervention activity is reduced to what Lipsky (2010, pp. xii) refers to as "benign modes of mass processing". The empirical results summarised in Tables 8, 9 and 10, reflect occupational therapy services as being largely service led rather than responsive to individual patient need. Service specific trends suggest predetermined programmes of assessment and intervention activity. These service specific trends were evidenced, both in terms of the assessment focus to specific activities of daily living areas, but also in respect to the mode of assessment adopted i.e. observed or reported. Intriguingly, assessments undertaken through observation rather than reported accounts were up to 7 times more likely to receive occupational therapy interventions.

From a critical realism transfactual perspective, a credible explanation could be that the areas of observed assessment and subsequent intervention are selected in response to areas of greatest patient need. However, the empirical evidence reflected patients with no or low level dependencies being selected for occupational therapy intervention in place of patients with greater dependencies contradicts this interpretation. This practice output distortion, as described by Bevan and Hood (2006) in their theory related to gaming behaviour, resulted in 70.3% of identified patient dependencies not being addressed by the respective Acute, Primary Care and Local Authority services in activities of daily areas where occupational therapy could have intervened. The consistency and extent of this phenomena supports a counterfactual theoretical explanation that considers situational influences at the macro and meso levels as contributing to the circumscribed occupational therapy service activity, such as the organisational specific service performance metrics.

The focus on quantifiable performance metrics, in the absence of the qualitative aspects of service delivery, arguably also distorted occupational therapy practice which resulted in equipment and adaptations as being the predominant mode of intervention across all service sectors (85.5%). This was despite Health based occupational therapists perceiving their primary professional focus as being one of patient rehabilitation (Acute 100% and Primary Care 75%). The occupational therapists expressed experiences of practice conflict between meeting professional aspirations for person centred care and the pull of meeting the performance measure targets within service. Participating therapists identified the absence of rehabilitation as having a negative impact on patient outcomes and also divulged instances of circumscribing service interventions to support the informal carer during the semi-structured interviews because of time restrictions. In the context that time was identified as the primary whole system service constraint by the Acute, Primary Care and Local Authority occupational therapists (69%), it is reasonable to theorise that equipment and adaptations are, on occasion, selected on the basis that it is less time intensive than the rehabilitative intervention option. This, in the context that the service performance measures have prescriptive timescale parameters, is a plausible explanation.

On reflection, the situational mechanisms in operation arising from the pre-existing structural conditions seem to have potency in influencing occupational therapy practice as inferred by Archer (1995). From a critical realist perspective, the causal potential of identified mechanisms, espoused by the profession, motivated by person centred care, appear to be in conflict with the mechanisms generated from these pre-existing structural influences. It is conceivable that the genuine aims of the profession to deliver person centred care are, as O'Neill (2002) proclaims, distorted by the structural mechanistic influences within the services' respective organisational contexts. The unintended practice and service based consequences, reflected within this research are, what Jackson (2011) sums up as being penalties arising from target driven practice within inter-organisational partnership working arrangements, leading to what Guilfoyle (2013) asserts is less effective public services. Fundamentally, performance targets result in workforce efforts and ingenuity being focused introspectively in efforts to achieve the targets at the expense of activity not subject to performance scrutiny.

Occupational therapists, in striving to meet their respective employing organisational priorities are directed to work in areas subject to performance scrutiny which are within the confines of their organisational structures. Practices out with the parameters of the employing organisation could be perceived as detracting capacity from meeting the organisation's primary objectives. The challenge of embedding new systems e.g. practice approaches, I.T., documentation is compounded by the level of uncertainty generated by the change itself. It is conceivable that occupational therapists faced with competing or conflicting mechanisms arising from the substantive situational influences and those generated from the new determine their course of action by discerning which mechanisms generate a response that is perceived as more congruent than the other(s) to the situation.

The emphasis placed on leadership by scholars such as Vangen and Huxam, (2003), Archer and Cameron, (2012), Boulton (2012), Stensaker and Falkenberg (2007); including those within the profession such as Best (2017) and MacGregor (2015), underscores the imperative to alter the situational influences within the respective organisations. The organisational expectations, perceived or otherwise, require to be dismantled and strategies that engender workforce permissions and confidence require to be established, supported and embedded. From a critical realism perspective, counterfactual thinking could theorise that the espoused commitment of the participating occupational therapists to the service redesign principles and measures are genuine but are contingent on a situational context that is conducive for their implementation.

6.3. Action-formation Mechanism Based Theorising: Micro to Micro Level
Action-formation mechanisms operate at the micro-to-micro level. This type of mechanism links individual cognition to behaviour; i.e. how individual choices and actions are influenced by specific combination of desires, beliefs and opportunities. Critical realists maintain that a meta-theory which defines social reality in terms of agents interacting with structural emergent properties is required to underpin sociological enquiry. Mechanisms are considered to work through human agents who have the capacity to think and act in terms of causalities that produce context specific outcomes. This section focuses on the micro level subjective interpretations and accounts of the occupational therapists in respect to the introduction of the

continuity of care service redesign measures within their respective pre-existing structural contexts. This ontological individualism emphasis furthers the sociological empirical level understanding of individual action on the service specific variations observed within the empirical observations.

The subjective espoused perspectives and the actions of the occupational therapists within Acute, Primary Care and Local Authority services portray a paradox for the occupational therapy profession. The discrete occupational therapy service data demonstrated perceptible service specific variations in professional perceptions and practice. The professional divergence in the interpretation and implementation of the continuity of care service redesign measures evidenced within this research emerged from the data that provided an insight into the intra service professional mind-sets (reflected in chapter 5) and the habitual practice norms and tendencies (illustrated in chapter 4). The influences, values, reasoning and motivations of the occupational therapists within their respective organisational structures and the disparity between the espoused positions of the therapists vis a vis the actual behaviours and events in practice are explored. The identification of these underlying agential variables, at both the empirical and actual levels, contextualises the action formation mechanisms generated from the situational mechanism in operation within the respective organisational structures as described by Smith and Sewart (2005). This analysis and discussion draws on Lipsky's (1980, 2010) theory of 'Street Level Bureaucracy' to explore some of the agency/structure sociological considerations arising from this critical realist research. Lipsky's articulation of the public service worker's discretionary powers within the policy context is of particular relevance and interest within this research. Argyris and Schon's (1984) 'Theories of Action' is also considered to discern between the therapists' governing variables in considering the competing and/or conflicting mechanisms in operation as part fulfilment of the abduction and retroduction methodological approach adopted within this research.

6.3.1. Action Formation Mechanisms: Modified Barthel Index and Model of Human Occupation Screening Tool

The introduction of a unified evidence based assessment practice approach to occupational therapy services across Acute, Primary Care and Local Authority was

subject to mixed appraisal by the therapists in practice. Health based Acute and Primary Care occupational therapists credited the Modified Barthel Index (MBI)⁶⁰ as having utility in practice, whilst the Model of Human Occupation Screening Tool's (MoHOST)⁶¹ utility in practice was considered ineffective. The espoused reasoning centred on the MBI's perceived resonance with pre-existing professional practice which was deemed as responding to the respective health authority's policy priorities. The emphasis placed on the MBI being universally recognised as a valid assessment tool to communicate results across different disciplines inter and intra-organisationally was also revered as a positive attribute; whilst the simplicity of completing the tool was regarded as an imperative in the context of the perceived pressure of time within service.

Whilst these statements of justification are plausible, counterfactual data analysis suggests the potential for an alternative explanation. The first relates to the biomechanical premise of the MBI tool being aligned to the prevailing medical reductionist approach within the Health sector and the socio-historic underpinning of occupational therapy. As such, the tool's resonance within the Health based occupational therapy context is unsurprising. However, a second potential explanation may support a theory that the underlying causal mechanism is motivated by self-interests that arise from the conformity of this tool to the organisational practice approach norm. As Lipsky (1980) asserts, the sense of self through the resulting prestige and approval within the organisation is deemed as a persuasive influence in the public service workers' deliberations in exercising their discretionary powers. The therapists' need to secure their organisational colleagues' approval was intimated in the Health based therapists' articulations about the MoHOST, which was deemed as having limited utility, because medical consultants did not value the data generated.

In preference to adopting the occupational therapy specific MoHOST outcome measure, the occupational therapists sought to emulate the physiotherapists' numerically based outcome measure. The rationality of this "group think" mentality,

⁶⁰ The MBI is an ordinal scale used to measure performance in a range of activities of daily living and served to reflect the dependency levels of patients.

⁶¹ The MoHOST is a standardised occupational therapy specific practice applied measure that seeks to explain how occupation is motivated, patterned, and performed through a patient's volition, habituation, and performance capacity

Chapter 6: Mechanism Based Theorising and Discussion

as described by Brooks (2003), where the profession relinquished the opportunity to establish and embed an assessment tool and approach more conducive to the espoused aspirations of the profession, could be indicative of the extent of the profession's desire for conformity to the pre-existing structural contexts. If this is the case, the convergence of the situational influences on the action-formation influences are reflected as the occupational therapists' cognitive reasoning which are derived from contextual influences

The dissonance experienced by the health based occupational therapists in extending assessment and intervention practice parameters as part fulfilment of the service redesign, was epitomised and magnified within the MoHOST documentation structures. Where the MBI design was congruent with the therapists' existing practice, the MoHOST created a conflict in extending the assessment parameters to include the psychosocial elements of a patient's wellbeing. The action was non-compliance in routinely completing the MoHOST tool. In deliberating potential reasons for this action, counterfactual thinking presents a theory for consideration which infers that this action may have been fuelled, in part, by the therapists' need to preserve a sense of personal competence. In accordance with Argyris and Schon's (1974) theory-in-use, this behaviour reflects a model I response which results in the situation remaining fundamentally unresolved. The therapists' pre-existing governing variables are not questioned nor redressed, despite acknowledgement by the Health based profession that the occupational therapy service is circumscribed and patient needs are not being addressed.

The Local Authority occupational therapists shared their Health based colleagues' perspective on the MBI as the tool's utility within a social care context was also considered as relevant in practice. The biomechanical approach transcended the health and social care divide; a reflection of the occupational therapists' share professional origins. The case example of patient x within this research however, suggests a variation in the practical application of the MBI, resulting in significant differences in patient dependency ratings. The reasons for this can only be speculated, but the differing perspective on the utility of the MoHOST presents some insight into the fundamental difference in the profession's practice approach that

may enlighten as to the difference in the inter-tester variance evidenced within the MBI.

Contrary to their health counterparts, the MoHOST resonated with Local Authority occupational therapists' situational context in that their employing body adopted a predominant social model of care commensurate with the psychosocial dimension of the MoHOST. This pre-existing situational context, combined with the medically orientated professional origins of the Local Authority occupational therapists may have culminated in an advantageous context from which to implement the biopsychosocial practice approach within the auspices of the service redesign. The Local Authority based occupational therapists valued the psychosocial dimension of the assessment tool as it resonated with the organisation's prevailing approach. Its utility was expressed in terms of the structure the tool provided to evidence the reasoning and decision making in practice within a politically charged organisational context. The underlying action-formation mechanisms therefore appear to include the Local Authority occupational therapists' motivation to justify and protect their professional decision making within a political context, where political masters challenge and overrule decisions based on political incentives.

The occupational therapists' perspective on the MBI and MoHOST was arguably also influenced by the location of the assessment i.e. home or ward setting. The action-formation mechanisms generated may have arisen from the occupational therapists' experience of undertaking an assessment within the different situational contexts. The MBI's simplicity and ease of implementation responded to the volume and pace of the ward based assessment activity which reportedly could be commenced and finalised within hours of receiving the patient within service. Local Authority occupational therapists, who had experience of a ward based environment as part of the in-reach redesign measure, shared their Acute colleagues reservations as to the utility of the MoHOST within an institutional environment. The ward environment was considered as not being conducive to obtaining the level of information required to complete the MoHOST. This explanation however does not translate to the Primary Care occupational therapists' reservations as to the MoHOST's utility in practice. Primary Care occupational therapists operating within a community context also perceived the MoHOST as having limited utility in practice.

The community based occupational therapy service perspective suggests that the action-formation mechanisms generated are derived from alternative sources that may be premised on more intrinsic influences.

Counterfactual thinking from a critical realism perspective considers that the habitual practices (Lipsky, 2010) within Health based occupational therapy services could provide an explanation in part for this conundrum. The Health based Acute and Primary Care occupational therapists were influenced by the situational context in which they are employed. The values, assumptions, theories, beliefs, concepts, rules, attitudes, routines, norms and skills that underlie the therapists' governing variables and subsequent actions, as described by Argyris and Schon (1974), are shaped by the predominant positivist approach within the Health service context in which they are employed. The emphasis on the positive biomechanical aspects of patient care could have resulted in the unintended consequence of an occupational therapy workforce being ill-equipped and/or ill-placed to deliver on the psychosocial element of the central Government's Third Way policy agenda.

The resulting challenge to the Acute and Primary Care occupational therapists' governing variables may have induced a sense of professional distress, anxiety and/or frustration (Shultz, 2012) arising from the dissonance experienced. The occupational therapists' initial subjective reaction to this challenge appears to have been the adoption of single loop learning strategies. The perpetuation of behavioural routines through the early non-acceptance of the MoHOST prevents the opportunity of new innovative solutions being discovered (Argyris and Schon, 1974). The Local Authority occupational therapists' pre-existing habitual practice norms corresponded to the policy directive expectations. As a result, the introduction of the standardised MBI and MoHOST assessment tools presented little challenge to their governing variables. Consequently, the dissonance experienced by the Acute and Primary Care occupational therapists was not experienced by the Local Authority contingent.

From a critical realism counterfactual thinking perspective, the absence of a challenge to the Local Authority occupational therapists' governing variables poses a question in regard to whether this staff group would have had the capacity to engage in double loop learning model 2 behaviours, if there had been a requirement

to change. The service redesign presented no significant requirement for the staff group to question the validity of their governing variables. Single loop, model 1 behaviours, as described by Argyris and Schon (1978), reaffirmed the congruence of the Local Authority pre-existing habitual norms to the service redesign measure and validated their practice approach. In effect, the Local Authority occupational therapists operated within their pre-existing practice norms and were not called to question or change their governing variables.

6.3.2 Action Formation Mechanisms: Integrated Information Technology Systems

The integrated Information technological solution was introduced across the occupational therapy services in Acute, Primary Care and Local Authority sectors to embed the MBI and MoHOST instigated practice development approach within the organisational structures. Both the MBI and the MoHOST standardised assessment and outcome structures were embedded within the social work patient information system and universal access to the specialist modules was secured for all NHS and Local Authority occupational therapists within South Lanarkshire⁶². This redesign measure created the opportunity potential to standardise professional documentation structures and practices across the service sectors and promoted unified data sharing protocols between the discrete occupational therapy services, both intra and inter-organisationally.

Occupational therapists across all service sectors espoused an unequivocal aspiration to have a unified IT infrastructure. This was raised during the mapping workshops which pre-dated the implementation of the service redesign measures. A driving motivation was the therapists' expectations that this system based solution would redress a number of identified practice based issues and frustrations. Accessing and sharing patient information within a single unified IT system was anticipated to reduce the incidence of duplicate data sharing activity for patients and address the duplicity of sourcing and documenting information for the profession. The IT solution was also viewed as having the potential to redress the intra service limitations and delays arising from the absence of inter-organisational data e.g.

⁶² Access to social work patient information systems secured for all NHS and Local Authority occupational therapists employed in the Care of the elderly within the South Lanarkshire geographical boundaries

details about a patient's homecare support to facilitate discharge from the Acute sector perspective; details of a hospital admission and discharge date from a community perspective. These underlying generative entities provided a potential context to activate agential mechanisms that would result in a positive outcome in terms of the successful implementation of the I.T. service redesign measure. Occupational therapists, across all service sectors, appeared genuinely motivated to embrace an I.T. development solution. However, a breach between the therapists' espoused position and their theories-in-use arose as a result of competing and conflicting mechanisms that were generated in the process of implementing the technological development. The emergent mechanisms were socio-culturally specific to the discrete service contexts but collectively prevented the successful implementation of the redesign measure universally.

The Local Authority socio-cultural context promoted the embedding of the I.T. solution. The Local Authority occupational therapists' pre-existing I.T. skills were founded on the pre-service redesign practice norm of electronically documenting patient assessments and interventions. The therapists' familiarity and confidence in the use of I.T. generated coexisting mechanistic tendencies which supported the Local Authority occupational therapists to successfully implement the I.T. service redesign measure. The pre-service redesign practice norm for occupational therapists within Acute and Primary Care was paper based documents located within the service files and/or ward based soap notes⁶³. Therapists were neither confident nor proficient in the use of I.T. As a consequence of their unfamiliarity and novice I.T. skill set, the implementation of an electronic system in practice was perceived as requiring additional time to complete. This was further compounded by preliminary I.T. NHS connectivity issues, which, although addressed timeously, resulted in a persistently held belief that the system was unreliable. In a service context where therapists perceived time as the most prevailing service constraint, the mechanisms generated conspired against the full implementation of the I.T. service redesign measure.

⁶³ Soap notes: Patient progress notes held within the ward setting accessed by and updated by all of the Acute based members of the multidisciplinary team

On a cultural perspective, the development of the I.T. system, within a pre-existing social work technological platform, may have generated a conflict for a professional staff group, who were emphatic during the semi-structured interviews about the personal choice of being employed within the Health sector. As Smith and Seward (2005) highlight, the role of choice comes with its set of “power” and “liabilities”. The potential underlying unobserved entities arising from the power and liabilities incumbent in the therapists’ chosen role emerged as a point in case by the Local Authority occupational therapists within the context of describing the in-reach/outreach buddying experience

Local Authority therapists were acutely conscious of a potential perception by health colleagues that the service redesign was being driven from a Local Authority perspective and that the strategy could be perceived as a Local Authority take over. The ramifications of these cognitive processes (among others), if consciously or subconsciously operating within the Health based occupational therapists’ mind sets, could generate underlying mechanistic influences that would have the potential to weaken the resolve, not only in terms of implementing the I.T. service redesign, but as a consistent element that would challenge each component of the service redesign.

Unsurprisingly, and as the research evidence demonstrated, the entire Local Authority occupational therapy workforce adopted the I.T. documentation structure in totality, whilst Acute and Primary Care based occupational therapists enacted their discretionary powers (Lipsky, 1984) in its implementation. Only the Acute and Primary Care occupational therapists engaged in the research engaged its use; and this engagement was circumscribed to select elements of the unified I.T. infrastructure i.e. MBI.

The occupational therapists’ practice experience of the MBI and MoHOST and the action-formation mechanisms activated as described in section 6.3.1. were reflected in the implementation of the I.T. service redesign measure. It appears that the preliminary positive mechanistic entities were thwarted, in part, by the Acute and Primary Care based occupational therapists’ perspective of the MoHOST standardised assessment and outcome measurement tool. The I.T. patient

information system's inclusion of the MoHOST tool within the specialist module created a conflict for these therapists. The response was non-compliance both in practice and subsequently within the I.T. module. The proposed system improvements were no longer congruent with the Acute and Primary Care occupational therapists' governing variables and expectations of the system development. As a result, the preliminary positive mechanistic potential identified within the service mapping exercise was not activated and was superseded by competing mechanisms that curtailed implementation to within the therapists' governing variables (Argyris and Schon 1974). This dissonance experienced by the Acute and Primary Care occupational therapists was not experienced by the Local Authority occupational therapists. Transfactual analysis would suggest that this outcome is predicated on the basis that the both the MBI and the MoHOST were validated in practice within this staff group, combined with the fact that the I.T. platform was familiar to the Local Authority based occupational therapists. As such, the implementation of the tool and the standardised documentation structures therein did not challenge the occupational therapists' governing variables as they were congruent with the services' pre-existing operational arrangements.

A further fundamental consideration that influenced the occupational therapists' perspectives on the practicalities of the I.T. service development relates to the validation by the extended multidisciplinary teams within the therapists' organisational structures. As a consequence of the specialist occupational therapy documentation module being embedded within the pre-existing social work electronic patient information system, colleagues within social work, who were also familiar with the electronic system, were able to directly access the specialist module. Mechanistic accounts by the Local Authority occupational therapists indicate that the I.T. system supported the productive sharing of patient information within the extended multidisciplinary social work team. Although some remedial revisions to improve the structure of the report printouts were identified by the therapists, the module was validated by both the extended occupational therapy staff group within the Local Authority context (including therapists not directly engaged in the research) and other disciplines within the extended social work multidisciplinary team.

Conversely, the NHS multidisciplinary team did not have direct access to the social work patient information system and were reliant on the occupational therapists to present the patient data generated from the specialist occupational therapy module. Given the therapists' predisposition as to the utility of the MoHOST component of the module, coupled with the staff group's non-compliance in completing the tool, the therapists' account of the system's inadequacy in providing useful information within a multidisciplinary context may have been informed from an incomplete or biased perspective. The potential for defensive reasoning, self-deception and counter-productive actions, as outlined by Argyris (2004), may have been enacted to validate and sustain the status quo within a situation where the therapists were experiencing dissonance. Counter-productive actions to maintain pre-existing documentation practice norms was evidenced within the research as Acute and Primary Care occupational therapists who, despite concerns about the time constraints within service, continued to complete the in-service documentation in addition to the electronic records.

Local Authority based occupational therapists did not have the option to continue the antecedent electronic documentation formats as they were discontinued at source. Despite the profession's apparent congruence with the service redesign measure, a poignant remark by one of the Local Authority occupational therapists during the semi-structured interview suggested that a degree of what Vangen and Huxham (2003) would classify as "collaborative thuggery" was being exercised by the service manager⁶⁴. As a consequence, the therapist conveyed that the options were limited; though Lipsky (2010) would argue that management actions cannot eliminate the discretionary power of public service employees as it is an irreducible component of street level bureaucrats' work.

The perceived or actual validation, or otherwise, of the electronic data sharing infrastructure by the therapists' peers and colleagues (and managers), within their respective employing organisations, in itself generated additional action formation mechanisms. The actions of the occupational therapists' colleagues in adopting or boycotting the IT system development, would, according to Schein (2004), trigger

⁶⁴ Service manager was PhD student during the implementation and evaluation of the service redesign

and activate mechanisms associated with the therapists' dependence on their colleagues' approval and support. It could be construed that the Acute and Primary Care based occupational therapists, in the interests of preserving their pre-existing cultural relations, did so, at the expense of fostering inter-organisational collaborative arrangements with colleagues. The consequences of such action has the potential, according to Huxham and Vangen (2005), to create cultural friction at an interpersonal level. It would seem that the partial compliance of the Acute and Primary Care based occupational therapists in the implementation of the I.T. service redesign measure had the unintended consequence of undermining the trust and respect of occupational therapy colleagues from other organisational authorities. Occupational therapists within Acute, Primary Care and Local Authority services outlined instances where they were presented with electronic records that were either incomplete, of an unacceptable standard or inaccurate. In effect, the Acute and Primary Care occupational therapists' partial-compliance with the I.T. documentation structures undermined the service redesign measure's objective of facilitating inter-organisational data sharing to promote patient continuity of care at an informational level. This appears to be substantiated in the empirical evidence within chapter 4, which portrays that the preferred mode of service documentation within NHS remained as the pre-existing paper files and that these were not shared with other occupational therapy services. The absence of any evidence of reciprocal behaviour in the implementation of the unified electronic documentation I.T. system was perceived by the Local Authority occupational therapists as a potential barrier to joint working. This perception is supported by Ostrom (1998), who cites reciprocity as a key variable in demonstrating commitment to a collaborative partnership and suggests that its absence leads to collaborative inertia.

6.3.3. Action Formation Mechanisms: Unified Management Arrangement

The introduction of an occupational therapy service coordinator with delegated responsibility across the Acute, Primary Care and Local Authority service sectors was intended to provide a cohesive approach to the management of the occupational therapists engaged in implementing the service redesign measures within this research. The service coordinator had delegated responsibility for the identification and allocation of patients, the supervision of occupational therapists during the casework associated with the service redesign measures and

responsibilities in case closure activities on completion of service interventions. The introduction of the intra-service coordinator presented different challenges to the pre-existing governance and practice environments within Acute, Primary Care and Local Authority service sectors. Acute based occupational therapists were, within the traditional service arrangements, autonomous in caseload management from the identification, self-allocation to the discharge of patients within service. Primary Care and Local Authority occupational therapy personnel were familiar with line management allocation and closure processes. All were familiar with line management supervision structures, albeit Primary Care occupational therapists had operational day to day accountability to a professional manager from a different discipline and a professional accountability to an off-site occupational therapy manager. All practitioners, without exception, operated within both observed and unobserved settings that created opportunities for autonomous practice. Although professional discretion within the unpredictable context of public service to respond to discrete situations is acknowledged as a prerequisite to professional public service, for Lipsky (2010), the relatively private nature of the work results in freedom from scrutiny, self-governance, gaming activity and avoidance of accountability.

The occupational therapists' reaction to the unified management service redesign measure was in some respects the most overt demonstration of the level and nature of dissonance being experienced by the participating therapists. The semi-structured interviews established that all occupational therapists across the service sectors initially responded to the introduction of the coordinator with some trepidation. The nature, intensity and consequence of these consternations varied, but the underlying mechanistic entities suggested that the anxieties were founded on the perceived disruption of pre-existing professional management arrangements and governance standards. Each discrete occupational therapy service retained its own hierarchical structures and operational arrangements, the stability of which was directly threatened by the introduction of a service coordinator with no allegiance to any of the pre-existing service structures. The intent of this service redesign measure was to inject a fresh management perspective to support staff and provide permissions to disengage from existing structures and change practice in order to achieve the continuity of patient care objectives. The imperative was to foster a collective leadership process that transcended the organisational divide which Archer and

Cameron (2012) consider as critical in collaborative ventures. The emphasis was to engender shared ownership, power, permissions and control in the delivery and development of a service partnership that collaborated in person centred care.

The occupational therapists' articulation of the experience arising from the introduction of the management measure across all service sectors was one of bewilderment, uncertainty and pressure. The personal accounts of feelings of self-doubt and awkwardness reflects Schultz (2012) hypothesis that the introduction of organisational measures to affect continuity of care can give rise to staff distress. The independent management arrangement created an unfamiliar context which was not entrenched in habitual organisational norms nor reliant on the same mutual dependency or "cold war" reciprocity between practitioner and manager as described by Evans (2006) and Lipsky (2010). The managerial risks associated from not accommodating practitioner preferences did not carry the same currency in the independent management arrangement. Management systems through the introduction of the unified I.T. service redesign measure also accorded the coordinator with an overview not previously available to track patients and service activity. Descriptions by Acute occupational therapists reflected a degree of unease that the coordinator was aware of patients before they were. The capacity to exercise discretion and manipulate the nature and flow of information about patients and practice activities had been curtailed. The potential for the occupational therapists to manipulate the information available, as intimated by Lipsky (2010) was minimised and the constraining influence of practitioner solidarity on management was mitigated.

The rules of engagement within practice changed. The immediacy and direct nature of the management redesign measure generated a contextual change that directly challenged practitioners in respect to the profession's habitual routines that were not conducive to the realisation of continuity of patient care. The opportunity was created for occupational therapists to consciously consider their actions in the context of their espoused commitment to person centred care. The identified incongruence between the therapist's theory in use and the espoused theory, as described by Argyris and Schon (1980), was made transparent within this process and was no longer an underlying and intangible entity. Equally, the service

coordinator's efforts to directly guide the practice of the occupational therapists to achieve patient continuity of care challenged the therapists pre-existing strategies to redress any dissonance experienced in practice. The service coordinator's actions to prevent traditional habitual practices that did not serve the continuity of care objective thwarted the occupational therapists' tendency to conform to organisational norms as a strategy in the pursuit of self-interest and protection. Indeed, the occupational therapists from all three service sectors experienced the impact of the service coordinator's strategy in these areas and legitimised their frustrations by providing examples of the perceived repercussions of these actions on service delivery. Acute occupational therapists relayed it in terms of ward staff having expectations arising from the traditional operational arrangements e.g. occupational therapist visibility on the ward; Primary Care therapists concerns centred on time committed to assuming the extended role and functions within the service redesign approach, detracting capacity to honour the anticipated volume of patients registered within the traditional service statistical returns; and the Local Authority expressed reservations as to the additional time afforded to test cases in the context of the 28 day assessment service performance indicator. All accounts were predicated on the assumption that the pre-existing goals and associated values and practice were accurate. According to Argyris and Schon (1974), this is a reactive, control oriented response that reflects single loop learning strategies that do not facilitate the correction of error or promote learning at an individual level.

Lipsky's (2010) street level bureaucrat work recognises this phenomenon and would suggest that the actions of the service coordinator effectively removed the practitioners' defence mechanisms. When confronted with such interpersonally threatening situations, Argyris and Schon (1980) reason that practitioners are compelled to enact face saving actions that rely on tacit theories in use driven by a defensive mind-set. Occupational therapists within Acute care of the elderly services questioned the level of scrutiny and disclosed an objection to having their professional clinical reasoning questioned. The sensitivities within the staff group were such that experienced and senior practitioners were reported to demonstrate their level of frustration through unprofessional physical manifestations e.g. kicking doors. The appointed coordinator, who challenged practice, was not accepted as an authority figure and a formal complaint was submitted. This type of reaction is

classified by Argyris and Schon (1980) as model 1 induced behaviours. This defensive response to the dissonance experienced impedes an individual's capacity to examine and modify the values governing actions and circumscribes the development of new action strategies.

The Primary Care occupational therapy personnel originally also questioned the need for their clinical reasoning to be questioned. However, in-practice experience changed their perspective and the support from the coordinator was actively sought to promote development and ensure standards expected were being achieved. The management measure was ultimately recognised as part of the infrastructure to support the change process and was utilised to rationalise and negotiate numbers of test cases to be undertaken and to clarify the expectations within the change programme. These reactions suggest that the Primary Care occupational therapists had begun to modify the values governing their actions, making it possible to produce new action strategies that enable learning. This level of insight to alternative thinking is aligned to Argyris and Schon's (1974) definition of double loop learning and creates the potential for apperceptive habits synonymous with their classification of model II behaviours.

The Local Authority occupational therapists were familiar with the level of scrutiny that was introduced within the auspices of the unified management service redesign measure and, as a result, were not disconcerted by this element of the service redesign. However, the therapists disclosed a discomfort with the dual management accountability arrangements during the semi-structured interviews. The tensions described arose from securing permissions from both managers in respect to the activity undertaken as part fulfilment of the service redesign. The cultural frictions experienced by the staff group in complying with the service redesign measure as part fulfilment of the collaborative development generated, what Huxham and Vangen (2005) refers to as a tension between personal autonomy and accountability to their employing organisation. Permissions were sought to deviate from established organisational procedures and practice norms. Ultimately, the Local Authority occupational therapists were not faced with the same level of dissonance as their health counterparts in respect to being questioned about their professional reasoning. This was on the basis that the arrangements were already familiar to this

staff group and as a consequence the therapists' theories-in-use were congruent with their existing governing variables.

However, counterfactual thinking begins to question whether the allegiance to their substantive management arrangements, coupled with their concerns about defaulting on the 28 day service target (previously outlined), is indicative of the potential capacity for this cohort of therapists to adopt single loop, model 1 behaviours if confronted with a significant challenge to their governing variables; a consideration which will be explored further in section 6.3.4

6.3.4. Action Formation Mechanism: In-reach/Outreach Practice Arrangement

The in-reach/outreach practice arrangement was the ultimate service redesign measure implemented. This arrangement aimed to realise the service redesign objective of minimising the incidence of transitions of care by replacing the acute, episodic nature of service provision, as described by Corrigan (2001), by a longitudinal approach to patient care that transcended the Acute, Primary Care and Local Authority elements of the occupational therapy service. Therapists were supported to either in-reach into the hospital setting from the community based services or to outreach from the hospital setting to support patients back into the community. The stratified approach to the implementation of the service redesign acknowledged the challenges of collaborative working in context and recognises Huxham and Vangen's (2005) observations with regard to the cultural diversity, paradoxes and tensions inherent within collaborative ventures. Each of the precursor redesign measures (MBI/MoHOST practice development, integrated information technology systems and unified management arrangement) was incrementally implemented in efforts to resolve some of the universally recognised barriers to partnership working. The intent was to replace the pre-service redesign circumscribed model of patient care, as advocated by Corrigan (2001), by providing occupational therapists with the practice, system and management infrastructure to empower them to enact the in-reach/outreach service redesign measure.

The emphasis was on creating a collaborative inter-organisational alternative arrangement within and between the occupational therapy services that was

predicated on delivering continuity of patient care at an informational, management and relational level. This shared service strategy was designed to capitalise on the occupational therapists' single professional orientation and their homogeneity in the care of the elderly patient population. According to March and Olsen (1989) and Lax and Sebenius (1986), the inherent potential for collaborative working between organisations is dependent on shared service strategies based on mutual understanding, a collective will and a milieu of trust.

The quantitative data analysis results would indicate that the service redesign was successful in engendering a collaborative approach across Acute, Primary Care and Local Authority occupational therapy services which resulted in a reduction in the incidence of patient transitions of care by 34.7%. 26 out of the potential 75 transitions from within the cohort of 33 patients were eliminated. 7 of these were exclusively as a result of management actions that removed duplicate referrals to multiple occupational therapy services within the system, whilst the balance of 19 were as a consequence of the service's capacity to enact the inter-organisational in-reach/outreach practice arrangements.

However, distinctive sector patterns emerged within the data that reflected a significant variance in the capacity of the occupational therapists within the discrete Acute, Primary Care and Local Authority services to assume the prerequisite extended duty of care role in fulfilling the requirements of the in-reach/outreach service redesign measure. The Primary Care occupational therapy service was successful in completing 33% (3/9) of the identified cases intended for the in-reach/outreach practice arrangement; whilst their Acute and Local Authority counterparts successfully completed 80% (8/10) and 100% (14/14) respectively. Patient dependency levels did not appear to be a contributing factor to the variance in the therapist's ability to undertake the in-reach/outreach measure to completion. The average dependency levels of the patients within the respective service sectors all fell within the MBI rating scale category of moderate (61-90)⁶⁵.

⁶⁵ Acute service average 78.4, Primary Care service average 89.3 and Local Authority service average 63.8. (MBI scoring system 0-20 Total Dependency/21-60 Severe Dependency/ 61-90 Moderate Dependency /91-99 Slight Dependency)

An alternative explanation for the observed variance in the therapists' capacity to assume the in-reach/outreach service redesign measure to completion, is from a critical realism theoretical lens, drawn from the occupational therapists' pre-existing interpretive schemes that are embedded within their respective service's social structures. As such, the therapists, operating as autonomous agents, are considered to be influenced by the social settings in which they practiced as their governing variables are shaped and informed by their employing organisation's priorities and practice norms. The relative impact of the therapists' governing variables in practice was reflected in terms of the levels of dissonance or conflict therapists experienced in the implementation of the in-reach/outreach service redesign measure. Acute, Primary Care and Local Authority therapists all described, to varying extents, a sense of being out of their comfort zones when implementing the in-reach/outreach service redesign measure. The subsequent decisions and actions taken by the therapists in response to the dissonance experienced, highlighted the prevailing mechanisms in operation. These behaviours and actions enacted through practice reflected the level of congruence between the therapists' espoused position in respect to person centred care and their theories in use evidenced at an actual level within context.

The longitudinal practice approach inherent within the in-reach/outreach practice arrangement received a positive endorsement from the occupational therapists within the Acute, Primary Care and Local Authority services. As in Schultz (2012) study's findings, the respective occupational therapy service personnel recounted that the redesigned service approach offered a more personalised service to the patient, resulting in enhanced levels of patient care. Furthermore, the majority of therapists, (10/13) across all three service sectors also described professional fulfilment and satisfaction arising from the redesigned service arrangement. Positive professional and service benefits associated with developing an awareness of the role of occupational therapy within different service sectors was also proclaimed. These affirmative assertions were, however, subverted by the therapists' descriptions about their experience of the extended duty of care responsibilities associated with the in-reach/outreach practice arrangements. The degree of professional distress, anxiety, grief and frustration evidenced in Schultz's (2012) study was depicted in the reported behaviours of the participating therapists. The

extent to, and the nature in which this was manifested, differed across the service sectors.

Acute based occupational therapists were described as indignant about the expectations being imposed by the in-reach/outreach service redesign measure to the extent that staff were expressing their frustration through aggressive physical manifestations. Management accounts indicated that the staff were threatening to seek independent advice from their Human Resources Department and the Union and that significant levels of management intervention were being exercised to safeguard the interests of the service redesign. This apparent extreme reaction reflects the degree of personal conflict experienced by the Acute occupational staff group. On considering this micro level presentation, the potential underlying causal conditions were explored through the critical realism methodological process of retroduction. The practice and system service redesign measures (shared practice approach, a single IT system and a unified management arrangement) individually and collectively presented the Acute based occupational therapists with an intense challenge to their governing variables derived from their pre-existing practice and system arrangements. The underlying mechanisms generated from these precursor measures could have culminated in a level of dissonance experienced by the occupational therapists that could not accommodate the challenge presented by the introduction of the outreach measure. Although this service redesign measure supported the strategic objective of shifting the balance of care into the community, the experience could have been interpreted as a further erosion of the Acute based occupational therapists' unique practice context. The affiliation to the Acute setting and multidisciplinary team was palpable and therapists sought to preserve their status and role within this context at the expense of pursuing the service redesign aspirations (Graph 13).

Acute based occupational therapists, having considered themselves to be in a strong position to undertake the extended role, were challenged in the implementation of the service outreach redesign measure. The culmination of the practice shift to a focus within the community context, in addition to the practice paradigm shift (MoHOST) and the IT and management system changes, generated a heightened level of dissonance. This arguably provides a plausible explanation as to the contributing factors that generated the intolerable tension experienced by the

Acute based occupational therapists that resulted in the behaviours manifested. The theory that the in-practice buddying and management arrangements accentuated the experience of professional displacement and raised concerns about the loss of professional identity, as described by Saultz (2003) has explanatory coherence from a critical realism perspective. As a potential consequence of the uncertainty generated, empirical events were noted where professional behaviours appear to have regressed. This included undertaking unnecessary, but familiar, therapeutic interventions, in efforts to regain control e.g. continuing service interventions with patients where the intervention was acknowledged by the therapist and confirmed by the service coordinator as complete.

From a macro and meso level perspective, the causal condition of the service redesign being implemented as a uni-professional programme of change which transcended three organisational structures created a level of complexity in terms of the management of the change process. Despite the acknowledged service redesign benefits to the patient, the profession and the organisation, the practicalities of managing the service redesign was cited by the occupational therapy managers as being prohibitive in the service redesign's full implementation. The situational influence of the management perspective on the cognition of the occupational therapists in practice can only be speculated. However, it is plausible to consider that this sentiment permeated and contributed to the causal mechanisms that served to undermine the implementation of the service redesign collaborative venture. This was expressed in terms of the intra-multidisciplinary arrangements being identified by the therapists as a prerequisite to any collaborative development in the future. In order to counteract some of the shortfalls of collaborative service redesign models such as this, the substantive management arrangements within change management programmes require what Stensaker and Falkenberg (2007) would characterise as sophisticated and advanced sense making capacities that delivers beyond the technical problem solving.

Primary Care occupational therapy colleagues were also reticent about assuming the extended duty of care responsibilities. The general consensus was they did not feel confident in assuming the extended duty of care responsibilities contingent within the service resign developments. Although less overt in their objection than their Acute based colleagues, the Primary Care therapists' non engagement in the

in-reach/outreach service redesign measure was more pronounced in practice. Gaming tactics, as described by Bevan and Hood (2006), were adopted to avoid the in-reach element of the service redesign measure in totality. The extended duty of care responsibilities within the realms of the local authority area of practice were tolerated; but only to the extent that it did not contravene their pre-existing service structure and professional arrangements. Any dissent from honouring the commitments within these traditional service arrangements were considered problematic and infeasible. The dissonance experienced resulted in the Primary Care based therapists rationalising and distancing the skill sets observed within the Local Authority role as discrete from the core occupational therapy profession's competencies. The Local Authority occupational therapists' ability to multi-task and their advanced levels of technical expertise was accredited to a specific type of therapist which was not synonymous with the self-perceived image of the Primary Care occupational therapist. Whether this was legitimate reasoning is questionable, but the Primary Care based occupational therapists justified their governing variables through this cognitive process. As a result, the mechanisms to preserve the stability of their pre-existing service roles were validated and prevailed.

The pace of change and the fact that the service redesign was required to deliver from within resources, with no backfill provision, was considered to be an additional pressure that did not take account of the current commitments and responsibilities of the service. Although intimated within all service sectors, Primary Care occupational therapists were the most resolute in their assertion, as despite empirical evidence to the contrary e.g. Local Authority undertaking 66.7% of the total number of in-reach/outreach casework allocated to Primary Care, the occupational therapists within Primary Care services did not perceive a reciprocity in the whole system workload management.

For Ostrom (1998), this perceived absence of reciprocity undermines the tenets of trust required for collaborative endeavours, and the willingness of therapists to interact collaboratively is, according to Ring and Van de Ven (1994), jeopardised. Notwithstanding the far reaching implications of this potential underlying mechanism in the implementation of the service redesign measures, the therapists' shared perspective on the pace and perceived resource deficits also present a plausible

mitigating explanation as to challenges being faced by the therapists. However, in the context that the service redesign measures, inclusive of the in-reach/outreach measure, were introduced over a period of 42 months, coupled with the fact that each therapist within the respective services was responsible for an average of 3 patients⁶⁶, the task was not considered as overly onerous. Counterfactual thinking suggests an alternative credible hypothesis is again related to the therapists' structural conditioning, derived from their interests built from their social positions and organisational cultural influences. The associated value commitments (and ultimate concerns) in practice generated the agentic mechanism that provides the most conceivable explanation, rather than the espoused structural resource shortfall.

The Local Authority occupational therapy services' reflections on the in-reach/outreach experience suggested that therapists were, as with the other service redesign measures, relatively confident in undertaking the extended role in practice with minor adjustments. Unlike their health service based counterparts, the patient test cases were perceived as uncomplicated and relatively easily absorbed within caseloads. The change process and timeframe for implementation was initially considered to be daunting, but operational experience in the implementation, coupled with the management support infrastructures, resulted in staff feeling less concern as their role was not considered to have changed significantly. The impact on the therapists appeared to be minimal as their governing variables were not significantly challenged. Accordingly, the congruence between the therapists' professional intention and the outcomes of their actions would, as Argyris and Schon (1974) describe, result in the therapists' theory in use being validated. The dissonance experienced by the therapists' health service based counterparts was not experienced to the same extent, and as a result the service redesign experience was generally considered as relatively stress-free.

However, despite the congruence with the principles of the service redesign measure, the Local Authority occupational therapists' governing variables were challenged in the process of implementing the in-reach/outreach service redesign measure on a number of fronts. The first related to time pressures, whereby

⁶⁶ Patients within the auspices of the service redesign

therapists described a tension between meeting the obligations of the pre-existing organisational assessment service standard of 28 days and delivering on the perceived time intensive service redesign measures of both the in-reach/outreach practice arrangement and the MoHOST documentation requirements. The espoused response to this experience of conflict was, similar to their Acute and Primary Care health counterparts, declarations as to what would require to be changed to mainstream the service redesign measure(s). The notable divergence from their health colleagues' responses was that the Local Authority based occupational therapists' theories in use i.e. behaviours, suggested a willingness, at least in part, to inquire as to the views and practice experiences and norms of colleagues within other service sectors. The Local Authority occupational therapists were the only cohort who, despite reservations, assumed the extended duties inherent within the discrete services and assumed the in-reach/outreach responsibilities in totality. These are the attributes Argyris and Schon (1974) describe as precursors to Model II theories in use, affiliated to double loop learning.

However, notwithstanding the therapists' endeavours, the congruence of the service redesign measure's principles with the Local Authority's pre-existing practice norms provided the contextual security for the Local Authority based therapists to explore and experience alternative models of practice. This experience exposed Local Authority based occupational therapists to different occupational therapy systems, organisational cultures and professional approaches, and generated professional disquiet which was primarily related to service specific processes, unfamiliar clinical procedures and approaches to patient care. The validity of the occupational therapy input within the Acute phase was specifically questioned, as the clinical environment was considered as not conducive to assessing patients effectively and the dominance of the medical model's reductionist approach to patient care was perceived as having limited value. Despite these reservations, Local Authority occupational therapists accommodated the Acute based service practice arrangements and approach; yet this was felt not to be reciprocated by Acute colleagues. Local Authority occupational therapists noted that the Acute based occupational therapists undertook the majority of the extended duty of care functions within the hospital setting. The expectation that Acute colleagues would discharge

their obligations under the auspices of the service redesign was not perceived to have been honoured.

As Ostrom (1998) postulates, this resulted in an absence of robust foundations for trustworthy inter-organisational collaborative working, and the facilitative mechanisms to counteract the diminishing commitment to collaborative partnership working were not successfully activated. Within this context, the buddying system implemented to provide peer support and shared learning experiences had the unintended consequence of exposing and accentuating practice differences that served to alienate rather than unify the occupational therapists. The intent of harnessing the occupational therapists' collective energy and initiative to create new knowledge and capabilities, as proposed by Nonaka and Takeuchi 1995, Hardy et al 1998 and Osterloh and Frey 2000, were also not realised in practice. The buddying arrangement provided an opportunity for peer scrutiny and uncovered the service specific variances that transcended the approaches to assessment, service intervention, risk management and communication (as evidenced within chapter 4) as elaborated in the case example of patient x. Underlying mechanisms were generated associated with sentiments of professional disapproval and disrespect, and indifference and distrust in respect to the future of partnership working. A public façade was sustained during the implementation of the service redesign measures, but the concerns expressed by the Local Authority occupational therapists during the semi structured interviews, highlighted the actual views and ramifications of the inter-organisational relationships at a micro interpersonal level. The inertia to collaborative working, described by Huxham and Vangen (2004), was engendered as a product of the new knowledge obtained from the service redesign in-practice experience, the results of which were viewed by the Local Authority occupational therapists as having a retrograde impact on the pre-existing joint working arrangements.

The Local Authority service's interface with the Primary Care occupational therapy service was perceived by both of the respective services as being aligned in practice. Despite Primary Care occupational therapists being employed by the NHS and the Local Authority therapists being employed by Social Work, this dual employment did not appear to present a problem as envisaged by Mountain (2001),

and did not reflect the health and social care divide characterised as the “Berlin Wall.” Intriguingly, the inability of the Primary Care therapists to assume the extended duties of the in-reach/outreach measure in practice did not appear to compromise the relationship with their Local Authority counterparts. Potential underlying mechanistic influences derived from the fact that the Primary Care occupational therapists’ practice base was in the community may have contributed to the perception that the reciprocity described by Ostrom (1998), was being honoured within the auspices of the service redesign. Conceivably, the level of peer scrutiny and professional judgement levied on Acute service based colleagues was, as a consequence, not applied to Primary Care colleagues to the same extent. Despite Primary Care based service’s limitations in delivering on the redesign measures, and the practice anomalies they shared within their Acute sector colleagues e.g. therapeutic interventions with patients with no identified need, the Local Authority occupational therapists appeared to perceive an affinity with their community based health service counterparts. The espoused mutuality of professional interest, as described by Ostrom (1998), ostensibly lay in the perceived rehabilitation focus of Primary Care occupational therapy services and the equipment and adaptations service focus within the Local Authority service sector. This service combination was considered as efficacious in the context of patient care in the community.

The Local Authority occupational therapists did, however, question the appropriateness of their curtailed equipment and adaptation services in achieving optimum outcomes for patients. The value placed on this by the Local Authority occupational therapists, in part influenced by their medical science based body of knowledge, resulted in the reported conscious professional adjustments in practice to accommodate rehabilitation as a mode of service intervention. The new values resulted in mechanisms to activate a different practice strategy, which reflects what Argyris (2004) would describe as a learning enabled model II response. The Local Authority occupational therapists detected and corrected a practice error in order to respond to patient continuity of care, but this adjustment was contained within the parameters of the therapists’ governing variables. The agency of the Local Authority based occupational therapists’ apparent acceptance of one health based service, whilst questioning the other, is arguably generated from influences that may not be

purely directed by altruistic professional interests associated with patient care. Argyris and Schon (1974) would suggest that the therapists' motivations may, in fact, be curtailed by professional and/or personal interests directed by governing variables such as those expressed by the therapists with regard to their professional preference and vested interests in non-institutional models of practice.

6.4. Transformational Mechanism Based Theorising: Micro to Macro Level

Transformational mechanisms are referred to by Hedstrom and Swedberg (1998), as the collective properties of individual actions and interactions which result in macro-level outcomes within the organisation(s). The emphasis within this research was to evaluate the macro- level outcome of a service redesign that introduced inter-organisational practice and system measures that transcended Acute, Primary Care and Local Authority based occupational therapy services. The service redesign aimed to capitalise on the inherent collaborative advantage arising from partnership working that was premised on reducing the incidence of transitions of care through measures that promoted continuity of patient care at an informational, management and relational level. This element of the analysis and discussion draws on Archer's morphogenetic approach (1995) which focuses on how structural conditioning affects social interaction and how this social interaction in turn leads to structural elaboration, structural status or decay. Argyris and Schon's (1974) "Theories of Action" is revisited and incorporated within the analysis in terms of the theoretical concept of organisational learning. The learning potential of the respective organisations is explored to further understand the constellation of the situational and action formation mechanisms that activate the transformational mechanisms resulting in the service redesign outcomes at a macro- intra and inter-organisational level.

Patterns of actions and interactions by the occupational therapists in response to the introduction of the four continuity of care measures were discernible within the discrete Acute, Primary Care and Local Authority occupational therapy services as outlined in sections 6.2.1 to 6.2.4. These presentations, according to Archer (1995), are as a result of the therapists' reactions and actions being culturally informed. In the contextual understanding that each organisation has its own goals, operating context and particular approaches, as described by Tsasis (2012), the emergent

cognitive reasoning and behaviours among the members of the respective service collective exemplify the organisational contexts they inhabited. The discrete service's respective rules and regulations contained within the service procedures, standards and targets provided a transfactual situational context with conditional powers from which Archer (1995) would argue, therapists were situationally conditioned. That is, the pre-existence of structural and cultural emergents shaped the social environment from which the occupational therapists within their discrete service sectors reasoned and acted. The agency of particular therapists in certain positions and their relationship to the specific service redesign measures determined the conditional influence of these situational contexts. The enactment of the associated mechanisms through the subjective mediation of the occupational therapists on an individual capacity ultimately converged to collectively constrain or facilitate the realisation of the service redesign aspirations. Only in this way can a plausible explanation be postulated as to why the same objective environmental stimuli, i.e. service redesign measures, gave rise to different service specific redesign outcomes in terms of minimising the incidence of transitions of patient care.

The service redesign measures introduced modifications to the occupational therapists' structural situational context by presenting occupational therapists with a suite of new operational systems. These transcended the established documentation service arrangements and standards, the management and governance infrastructures and the pre-existing practice parameters in terms of approach, emphasis and location. Each of the associated service redesign measures, i.e. Joint I.T. infrastructure, unified management arrangement, shared practice approach and in-reach and outreach practice arrangements, presented the therapists with an altered situational context with a range of alternative conditional situational influences. The agency of therapists, in responding to this change, evoked a confrontation to the pre-existing situational context which carried an irreducible tension for the therapists. The relative compatibility or incompatibility of the emergent properties arising from the service redesign measures to the therapists' values and self-interests acted as a determinant in the extent to which therapists engaged in the service redesign process. The different socio-cultural systems embodied within the Acute, Primary Care and Local Authority service

sectors contextualised the situational logic applied by the occupational therapists in response to the service redesign measures. The pre-existing organisational doctrines, theories and beliefs generated the objective limitations that Archer (1995) would suggest, circumscribed the therapist's agential subjective interpretation of the alternative structural influences embodied within the introduction of the continuity of care service redesign measures.

6.4.1. Transformational Mechanisms: Acute and Primary Care Occupational Therapy Services' Situational Logic

The prevailing generalised situational logic within Acute and Primary Care occupational therapy services, as defined within Archer's (1995) morphogenetic approach, was that of protection and containment. Argyris and Schon's (1974) model 1 single loop learning theory is closely affiliated to this logic and conceptualises the limitations of the learning capacity of the occupational therapists and the organisations within this predominant situational logic. The response by health based occupational therapists within Acute and Primary Care service sectors demonstrated a predominance of protective practices as their collective interest within their respective services was to defend their pre-existing situational context within the constructs of their own discrete service parameters. The mediatory mechanisms in operation were activated by what Archer (1995) would describe as complementary intra-service relations, which systematically reaffirmed the agential situational context. This resulted in actions that either reproduced traditional practice arrangements in their entirety, or contained any modification in practice to within the therapists' governing variables predicated on traditional practice parameters. Any innovative action promoted by the service redesign measures, which was considered by the collective to endanger the service specific collective interests were not activated and embedded in practice.

The rationale was articulated and justified in terms of the therapists' assumptions that the pre-existing professional values, service objectives and operational frameworks and strategies were correct. Both Acute and Primary Care occupational therapists perceived a derivative value to both patient care and organisational outcomes from the interventions provided by their respective services. The Acute

and Primary Care based occupational therapists' affiliation to their employing organisation's prevailing medical model practice approach to patient care was significant in their interpretation of, and response to, the associated service redesign measures introduced. These implicit sets of values determined the therapists' professional biases, as described by Argyris and Schon (1974), and therapists actively gauged the congruence of the service redesign measures against the pre-existing service practice and system norms in order to validate or reject their implementation in practice.

The operational obstructions generated from the service redesign's approach in practice presented practical problems for the therapists, as it impinged on a number of pre-existing situational structures. The therapists' frustrations arose from the extrication from the organisational and practice norms primarily associated with assessment, documentation, performance management and intra-organisational multidisciplinary working. All four service redesign measures introduced practice and system changes that were perceived as contingently incompatible with the pre-existing professional and service norms. This generated an incongruence between the therapists' espoused perspective and their theories-in-use. That is, despite the service redesign measures being universally acknowledged as having the potential to provide improvements in the quality of patient care and enhance levels of professional fulfilment in practice, the therapists' cognitive reasoning (outlined in chapter 5 and elaborated on in sections 6.2.1.to 6.2.4) suggests that the central precedence was on minimising the personal and professional conflict experienced. Therapists engaged in defensive mind-sets and evasive actions as a means to mitigate against the perceived threat of the service redesign, as opposed to embracing the altered situational context that could have potentially resulted in structural elaboration.

In effect, the emergent protective mechanisms and conditional powers arising from the incompatibilities were, on balance, greater than those countervailing mechanistic tendencies that were premised on the opportunistic potential of the service redesign measures. Consequently, therapists within both Acute and Primary Care services exercised their agential discretion, and the service redesign measures were tolerated to within the parameters of the occupational therapists' pre-existing

governing variables; theirs was a predominant situational logic of protection and containment.

However, specific actions exercised by the Health based therapists demonstrated instances where the situational logic of compromise, opportunism and elimination were exercised within context. For example, Primary Care occupational therapists sought direction and support from the co-ordinator (management service redesign measure) in efforts to clarify expectations and address detected limitations and errors in practice. This was presumably on the premise that new gains could be achieved through external relations, possibly influenced by the situational logic, as defined by Archer (1995), of compromise and/or opportunism. The Acute occupational therapists' explicit demonstrative behaviours and actions, such as kicking doors and threatening to engage personnel services or unions, denote a situational logic synonymous with elimination. These defensive behaviours sought to eliminate the threats to the pre-existing situational context by resorting to actions that were intended to terminate the implementation of the service redesign.

Archer (1995) and Argyris and Schon (1978) would proclaim that these strategies avoided the correction of detected errors. Despite the compelling empirical evidence which highlighted the detrimental consequences to patient care as described in chapter 4, therapists curtailed the opportunity to examine and modify the values governing their actions, the consequences of which resulted in a missed opportunity to learn, as the therapists directed their capacity to engaging in defensive actions which prohibited the emergence of productive collaborative professional strategies.

In summary, the multifaceted situational influences generated from the four service redesign measures activated underlying generative mechanisms operating at multiple stratified levels. The interplay of these mechanisms operated within a defined network of interlocking operations and manifested as the non-compliance and partial compliance within each of the four service redesign measure's operational arrangements. The generative powers of these collective actions resulted in Acute and Primary Care occupational therapy services achieving the service redesign objective of minimising the incidence of patient transitions of care in 80% and 33% respectively. The situational logic of protection and containment,

whereby health based therapists engaged in the service redesign measures to within what Argyris and Schon (1974) would describe as the parameters of their governing variables, facilitated the achievement of the service redesign objective in part. This however was transient and was only exercised during the implementation phase of the service redesign. The therapists' propensity to generate model 1 single loop learning responses reflects the professional group's overreliance on existing structures and established routines, as outlined in sections 6.2.1. to 6.2.4.

The limitations of the occupational therapists' capacity to learn and embed the new practice arrangements, within their respective organisational structures, predisposed their employing organisations to the associated O-1 organisational social system. The O-1 organisational social system is, in accordance with Argyris and Schon's (1982) theory on organisational learning, resistant to change and as a consequence, an altered situational context for practice was not realised. The pre-existing macro (and meso) level situational mechanisms were sustained. The governing situational logic of protection and containment within both Acute and Primary Care occupational therapy services therefore generated situational influences which resulted in a state of morphostasis within the respective organisations.

The scale, complexity and intensity of the challenges experienced within the collaborative venture was beset with diverse and stratified interdependent macro, meso and micro influences. These related to incongruent inter-organisational policy objectives, incompatible inter-organisational service infrastructures and context specific practice paradoxes and tensions. The social process of organisational sense making requires management and leadership strategies that develop change intermediaries that supports the activation of the identified underlying generative mechanisms. These should facilitate a context that supports the occupational therapists' engagement in double loop learning. The professions' capacity to engage in such learning strategies is critical to organisational morphogenesis and thus the realisation of successful collaborative ventures.

6.4.2. Transformational Mechanisms: Local Authority Occupational Therapy Service's Situational Logic

The governing situational logic within the Local Authority based occupational therapy service was also that of protection and containment, albeit the protective actions assumed by these occupational therapists were within the context of a service redesign that was aligned with the service's pre-existing service values, processes and practice norms. The pre-existing structural and cultural properties within the Local Authority occupational therapists' practice context was conducive to responding to a greater range of patient dependency levels than their Health based counterparts. The therapists' familiarity with community based practice and established collaborative approaches to patient care responded to the social dimension of the MoHOST. This, coupled with the therapists' specialist knowledge in the assessment and coordination of the primary mode of therapeutic intervention i.e. equipment and adaptations (81.5%), created a situational context whereby the therapists' pre-existent professional values and skill sets were commensurate with the service redesign ethos. Likewise, the therapists' pre-existing knowledge of, and levels of proficiency in the I.T. service redesign measure resulted in the Local Authority occupational therapists being competent in its implementation. Finally, the service redesign's governance arrangements were an extension to the therapists' pre-service redesign management approach and the levels of scrutiny and accountability were therefore not unfamiliar. These precursory service redesign measures collectively engendered a compatible structural context that confirmed the congruence of the therapists' theories-in-use at multiple levels. As a result, the therapists adopted the service's traditional practice arrangements, with minor adjustments, to successfully engage in the implementation of the in-reach/outreach service redesign measure.

The compatibility of the service redesign measures with the service's pre-existing service arrangements served to generate positive reinforcing inducements that reaffirmed the agential situational context and legitimised the therapists' actions of practice reproduction. As a result, the experience of the service redesign was comparatively problem free for the Local Authority based occupational therapists, resulting in the professional corroboration of theories and confirmation of value base. This, in turn, validated and reinforced the therapists' sense of professional

self, role, status and competence. Contrary to their Health based counterparts, strategies of containment by the Local Authority based occupational therapists were kept to a minimum and were reserved for instances which presented incompatibilities e.g. in-reach activities which required assuming professional responsibilities within the Acute hospital/ward setting, where the value of this practice was perceived as limited. The operative consequence manifested as a positive effect in terms of the Local Authority achieving the service redesign objective of minimising the incidence of transitions of patient care in 100% of cases. Furthermore, the Local Authority based occupational therapists assumed responsibility for the patients (8) who were not successfully managed by Health based colleagues in the implementation of the in-reach/outreach service redesign measure.

However, the congruence experienced by the Local Authority occupational therapists within the auspices of implementing the service redesign measures, resulted in the therapists not being confronted with significant ideational challenges. Archer (1995) would suggest this circumscribes the therapists' experience of the service redesign measures as little more than variations on the pre-existing practice and system structural arrangements within service. The participating occupational therapists were not required to elaborate on their intellectual capacities in order to accommodate an extensive change in their operations, and as a result were not challenged to make corrections to pre-existing values through measures that adopted double loop learning strategies. According to Archer (1995), this situational logic would, over time, generate counterproductive mechanisms that would erode the Local Authority based occupational therapists' capacity to accommodate innovation, as the pre-existing practice arrangements would intensify and barriers would emerge as cognate notions develop. In accordance with this thinking, the collective interest of the Local Authority occupational therapy staff group would be the preservation of the established practice arrangements. Adjustments would be discouraged in the interests of socio-cultural uniformity. In defending these acquired rights, tolerance of violations would not be acceptable as loss would be incurred to the Local Authority based occupational therapists' collective vested interests.

The Local Authority occupational therapists' disclosure of reservations as to the future for partnership working with colleagues within the Health service sector (with a particular emphasis on the Acute sector) was fundamentally based on the inter-service practice vacillations experienced in the implementation of the service redesign. The tension in practice evolved from being a policy and professional consideration between the relative merits of institutional versus community based practice, to a shift that questioned the integrity of practice and competence of Health based colleagues. Sentiments of professional disapproval, disrespect, indifference and distrust emerged and threatened the future of partnership working. The view held by Local Authority based occupational therapists was that the pre-existing joint working arrangements had taken a retrograde step as a consequence of the heightened awareness of differences in practice. The generative powers and mechanistic potential of these emergent socio-cultural influences could, according to Archer (1995), provoke a protective situational logic that stimulates the augmentation of barriers to partnership working. Local Authority based occupational therapists, having secured a congruent situational context in the implementation of the service redesign, would reinforce the reproduction of in-service practice norms whilst having the potential to generate remedial action to redress the perceived contraventions to these norms within the existing partnership arrangements. The protective situational logic operating in this context was successful in minimising the amplification of deviations that were not conducive to meeting the service redesign objectives. However, the protective situational logic shift from being successful to being a morphostatic influence that reduces the capacity for structural elaboration is contingent on the context and the capacity of the Local Authority occupational therapists to engage in model 2, double loop learning where indicated.

6.4.3. Transformational Mechanisms: Implications for Organisational Learning and Collaborative Working within Acute, Primary Care and Local Authority Occupational Therapy Services

Organisational success is dependent on the organisation's ability to see things in new ways, gain new understandings and produce new patterns of behaviour (Argyris and Schon 1996). The prevailing situational logic of protection adopted across all occupational therapy services in the implementation of the service redesign presents a paradox to the respective organisation's learning capacity. The

capacity for organisations to learn and develop innovative strategies to realise different and sustainable organisational outcomes is dependent on the therapists' cognition. Organisational learning is premised on the therapists' agency in readjusting their underlying governing variables and modifying their actions in response to the rational exposure of irrational modes of individual and group behaviour (as outlined in chapter 4). The introduction of the practice and system changes within the service redesign aimed to activate, what Argyris and Schon (1974) classify as model II theories-in-use. The service redesign practice and system changes reflected the therapists' espoused commitment to patient continuity of care and were structured to support the therapists to transform their espoused theories to actual theories-in-use.

Despite the collective espoused commitment, the process of implementing the service redesign measures heightened consciousness as to the systemic errors and failings within the established practice norms in patient care. This consequently challenged the cultural and structural properties that informed the actions of the occupational therapists within their respective services. The therapists' response to the detection of error resulted in protective and defensive reactions and a situational context emerged whereby the therapists' actions, on an individual and aggregated level, were dominated by strategies to distance themselves from the personal and professional conflict experienced. The countervailing underlying mechanisms were not activated and the dissonance was not confronted nor addressed, resulting in the conflict remaining unresolved. The therapists' emphasis was on maintaining or regaining unilateral control in a changing situational context which was perceived as presenting a threat. Therapists reverted to single loop learning, model 1 behavioural responses in efforts to preserve their sense of competence, status and role as a strategy to mitigate against the negative emotions arising from the implementation of the service redesign measures.

The overreliance on pre-existing practice norms as a safe haven was reinforced by the transient status of the service redesign programme and the uni-professional nature of its design. The development of the internal environmental conditions to encourage double loop learning within the inter-occupational therapy service structures (via the introduction of the service redesign measures) was essentially

undermined by the co-existence of the external environmental conditions which were not subject to the change. A central reservation articulated by the health based occupational therapists about the applicability of the service redesign measures was in terms of their congruence with the intra-organisational multidisciplinary team's practice norms and expectations. This rationale created the appearance of credible external conditions within the system that inhibited double loop learning, whilst simultaneously providing the occupational therapists with a plausible face-saving justification for nonfulfillment of the service redesign measures.

The accountability and responsibility in respect to the more intrinsic personal limitations e.g. knowledge, skills and competence, were diffused and obscured in the interests of preserving the therapists' vested interests. The paradigm shift embodied within the service redesign measures, from that which was embedded within a medical model approach to one that incorporated a social model of care, was not congruent with the health based occupational therapists' pre-existing situationally informed governing variables. As a consequence, the occupational therapists' initial espoused commitment to improving the quality of patient care through measures that promoted continuity of care was, paradoxically, relegated in the process of implementing the service redesign measures.

The dominance of Model I theories-in-use, stimulated by a prevailing situational logic of protection, inhibited genuine individual learning. As a consequence, malfunctions within the occupational therapists' respective social systems were sustained. Defensive characteristics emerged that manifested as disruptive and evasive behaviours culminating in inter-sector professional distrust and disapproval. This led to service fragmentation, duplication of effort and escalating error as anticipated by Lowndes and Skelcher (1998). In resorting to using Model I single loop strategies, therapists created Organisational I (O-I) learning systems outlined by Argyris and Schon (1982) and generated a situational context that was not conducive to collaborative or partnership working. The accentuation of the structural and cultural diversity between the respective occupational therapy services emphasised the inconsistencies of the inter-service objectives in practice and subverted the mutuality, trust and reciprocity tenets of collaborative working as defined by Ostrom (1998). The tensions generated created a milieu of distrust rather

than that of trust, irrelevance rather than mutuality and disengagement rather than reciprocity.

The occupational therapy services within the respective organisations were not only constrained by previous learning experiences, as described by Levitt and March (1988), but were now confronted with the ramifications of the service redesign legacy which heightened the professional inter-service consciousness of competing value systems, variations in service approaches and disparities in practice standards. This resulted in inter-service reputational damage.

Moreover, the relative alignment of the pre-existing organisational archetype to the policy directive aspirations (embodied within the continuity of care service redesign measures), determined the distribution of power in terms of the cultural and structural hegemony in favour of the Local Authority situational context. The related perceptions harboured by the Health based occupational therapy contingent was that of a significant power imbalance, creating a sense of a Local Authority take-over rather than a collaborative venture. In such cases, Hardy et al (1998) and Phillips and Brown (1993) would propose that a façade of spurious trust is created. The absence of genuine trust and reciprocity between the occupational therapists within the Acute, Primary Care and Local Authority service sectors undermined the potential to harness the energy and initiative to create new knowledge and novel capabilities as described by Nonaka and Takeuchi (1995); Hardy et al (1998); Osterloh and Frey (2000).

The differences within the respective occupational therapy services activated mechanisms that ultimately converged and contributed to an inter-occupational therapy service collaborative inertia. The homogeneity of the occupational therapy profession's epistemological underpinnings, perceived as a potential advantage within the professional literature (Blom-Cooper 1989, Mountain 2001, College of Occupational Therapy 2002), did not activate countervailing mechanisms to the extent that it resulted in a collaborative advantage. The inherent potential of a single profession transcending the inter-organisational barriers to collaborative working⁶⁷ was thwarted as a consequence of what Powell (1990) describes as

⁶⁷ Collaborative working synonymous with the term partnership working within this research

complementarities i.e. the different interests and motivations of the occupational therapists whose professional orientations were immersed within the structural and cultural influences within their respective employing organisations.

For Ostrom (1998) and Ring and Van de Ven (1994), the complex, non-linear and emergent nature of collaborative working requires to be developed over time with opportunities for therapists to develop interpersonal trusting relations through repeated reciprocal interactions. The professional interaction afforded within the parameters of the research timescale operated at a formal inter-service arrangement in the implementation of the service redesign measures. The required shift from that of being a formal partnership agreement to commitments based on psychological contracts is observed by Huxham and Vangen (2005) as requiring an inordinate amount of time at an organisational cost of low productivity during the process. The political compulsion to reflect tangible results quickly, as described by Newman (2001) is largely devoid of the diachronic perspective on complex organisational change. In the absence of sufficient time, the initial counterproductive situational mechanisms to the policy aspirations of collaborative working embed and inter-organisational damage ensues.

In conclusion, the “golden opportunity” heralded within the Joint Future (2000) policy for the occupational therapy profession to spearhead the collaborative intent of the central government strategy and deliver on the associated continuity of patient care aspirations embodied within the College of Occupational Therapy’s (2002) modernisation strategy was a complex and multifaceted affair. The endeavour was influenced by multiple, stratified, observed, unobserved and obscure underlying and interacting mechanistic tendencies within an open, emergent and self-organising situational context. The profession’s capacity for transformational change was disabled by a situationally influenced propensity for defensive mind-sets, which distorted interpretations leading to self-deception and counterproductive practice. These behaviours were counterintuitive to the partnership working objectives and constrained the realisation of the service redesign’s continuity of patient care aspirations. All 3 services remained in a state of morphostasis as the occupational therapists retained their pre-existing interpretative schemes to inform their actions. Furthermore, the self-reinforcing behavioural routines, observed within this research,

suggest that the profession's potential for transformational change in the future may be compromised if individual (and organisational) learning continues to be predominantly confined to single loop, model 1 systems.

The ramifications of the profession's prevailing single loop learning strategies in practice is significant in explaining the missed opportunities of the past (Mountain 2002, Blom-Cooper 1989). Recent studies undertaken by Best (2017) and MacGregor (2015) suggest that the profession of occupational therapy continues to be tested by the challenges of integration. However, the studies reflect a dawning realisation by practicing occupational therapists of the futility of focussing exclusively on structural constraints to integration. Indicators suggest that an increasing emphasis is being placed on communication, leadership and joint education as the primary enablers to realising integrated working. This change in professional perspective is fundamental to capitalising on productive learning strategies that could realise the transformational potential of occupational therapy in the future.

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

7.1. Introduction: Revisiting the Critical Realism Research Design and Research Aims

This PhD was engaged in an evaluation research of a practice and system service redesign within care of the elderly occupational therapy services that transcended three organisational structures; namely NHS Lanarkshire Secondary (Acute) Care, NHS Lanarkshire Primary Care, and South Lanarkshire Council. The evaluation research was undertaken concurrently to the intervention programme being designed, implemented and developed and adopted a formative evaluation approach with a sequential explanatory research design that embraced the ethos of critical methodological pluralism within a realist ontology (Creswell and Plano Clark 2007). The methodological pluralism advocated within critical realism and adopted within this PhD's research design served to provide both quantitative and qualitative data to inform the exploration and explanation of the social phenomenon under study.

The empirical results detailed in chapter 4 presents a quantitative perspective of reality, reducible to events that could be observed. This representation of events at the actual level illustrates the pattern of regularities in respect to the nature, content, frequency and duration of occupational therapy activity within Acute, Primary Care and Local Authority services and quantifies the service redesign results in terms of organisational outcomes and the outcomes associated with the services delivered to patients.

In order to transcend the purely empirical observations of the social phenomena under study and attempt to explicate the hermeneutic social conditions, abstract research methodology was adopted which aimed at theoretically describing activated mechanisms at the macro, meso and micro levels in order to hypothesise how the observed events can be explained (Chapter 5 and 6). In this research, the sociological theorising tools utilised incorporated Danermark et al (2002) explanatory framework as a methodological structure to develop middle range

Chapter 7: Conclusion - Reflections and Recommendations for Future Research theories (Chapter 2) and Hedstrom and Swedberg's (1998)⁶⁸ model of social action to structure and present the mechanism based theories at the macro, meso and micro levels. This incorporated Archer's (1995) morphogenetic situational logic explanation and Argyris and Schon's (1978) organisational learning theory to describe, contextualise and present the findings (Chapter 6). These sociological tools and theoretical concepts have defined my ontological and epistemological position and underpinned my style of explanation presented within this thesis.

The service redesign sought to create inter-organisational service system improvements and practice changes that aimed to minimise the incidence of, or enhance the processes associated with transitions of care within and between the Acute, Primary Care and Local Authority occupational therapy services. Haggerty et al's (2003) concept of patient continuity of care was adopted and underpinned the service design aspirations by promoting continuity of care at the "informational", "management" and "relational" levels of care. This evaluation research sought to develop a theoretical understanding of the outcomes of introducing a practice and system service redesign within three discrete care of the elderly occupational therapy services within Lanarkshire. The objective was to describe the underlying mechanisms and explore the reproductive or transformational influences of these on the service redesign outcomes within this inter-organisational health and social care public service context.

The service redesign measures introduced responded to the central government Joint Future (2000) policy directive and included four discrete but inter-related service redesign measures. These were:

- (5) A unified evidence based practice approach implemented through the adoption of the Modified Barthel Index (MBI) and the Model of Human Occupation Screening Tool (MoHOST).
- (6) A single shared IT system that facilitated the sharing of information across the occupational therapy services within each of the organisations. Both the MBI and MoHOST were incorporated within the single shared IT system.
- (7) In-reach and outreach occupational therapy practice arrangements that facilitated occupational therapy patient care beyond the traditional organisational

⁶⁸ Building on Coleman's macro-micro-macro model of social action

Chapter 7: Conclusion - Reflections and Recommendations for Future Research boundaries. Therapists were facilitated to continue to support an allocated patient either into the hospital from the community setting or follow the patient out to the community once discharged from hospital.

- (8) The introduction of a service coordinator to implement a unified approach to the operational management of the occupational therapy services within the research site.

7.2 Research Findings: Inter-organisational Transitions of Care Profile

Transitions of care, as an internationally recognised major quality challenge (Reed et al 2005), is an implicit element of the central government partnership/integration policy framework and a central consideration within the auspices of the service redesign. The pre-service redesign baseline data reflected that the incidence of active⁶⁹ and passive⁷⁰ transitions of patient care across Acute, Primary Care and Local Authority occupational therapy services accounted for 19.8% of the annual referrals. The prevalence of the identified transitions of patient care between services is symptomatic of the established tripartite public service organisational structures described by Corrigan (2001). These discrete specialised departmental structures within health and social care has resulted in multiple occupational therapists and settings being involved in the process of patient care.

This research evidenced that the occupational therapy profession's practice was shaped by, and contained within the respective employing organisation's structural and cultural parameters. Compensatory measures to mitigate against the resulting discontinuity of care, as described by Kohn et al 2000, Haggerty et al 2003 and Freeman and Hughes 2010, were adopted, resulting in the longitudinal approach to patient care being relinquished. This was exercised by transitioning patients on to other occupational therapy services within the system for ongoing intervention. The transitions of care configuration between the occupational therapy services epitomises the acute, episodic nature of the service delivered and illustrates the single direction of flow from Acute based occupational therapy services into the community; a service profile commensurate with the central government's Shifting

⁶⁹ Active transition refers to the act of one occupational therapy service actively referring a patient to another occupational therapy service

⁷⁰ Passive transitions refers to the incident whereby a patient, already known to one occupational therapy service is picked up by another occupational therapy service without an active referral being made by the original service

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

the Balance of Care (2009) policy aspirations to focus on community based service responses to care. However, the incoherence and duplicity engendered within the system is an unintended consequence of the service approach. The absence of a whole system governance infrastructure to monitor the activity and consequences in totality, generated inefficiencies within the system and created a public service context that Balint (1957, pp.93) describes as the “collusion of anonymity”. The surreptitious nature of the collusion within the context of this service redesign was revealed through an overview of the empirical data that tracked the continuity and quality of patient care across Acute, Primary Care and Local Authority services. Transcending the discrete organisational parameters for patient care and evaluating services from a whole system perspective demonstrated that the occupational therapy services evaded accountability to patient care as a result of the services’ operational arrangements being constituted from, and confined to, their respective employing body’s situational influences. Acknowledging the interdependency of the different parts of the system is promoted by Smith and Alderson (2005) and O’Neill, (2002), as being fundamental in combating the inherent weakness of synecdoche and countering the perverse incentives that contribute to defensive behaviours. Defensive behaviours were observed within this research and were stimulated by the introduction of this research’s service performance measures associated with patient continuity of care.

7.3. Research Findings: From Empirical Observations to Transcendental Reality.

7.3.1. Service Redesign Outcomes: Macro Level Organisational Perspective

From an organisational perspective, the empirical outcomes of the service redesign produced tangible improvements that would suggest efficiencies within the system. The results demonstrated that the service redesign objective of minimising the incidence of transitions of patient care was successful in that the number of transitions were reduced by 44.8%. In achieving this result, the number of occupational therapists engaged in the patient’s care pathway within a single episode of care was reduced from an average of 2.3 to 1.5 therapists and the patient length of stay within service was reduced by 35.6%. Although the number of direct contacts with patients across the whole system also decreased by 43.3%, the

direct contact within the discrete services either remained constant (Primary Care) or increased (Acute, Local Authority). In effect, patient contact with the same therapist was increased whilst the system's commitment in terms of resources was reduced. This, combined with the recalibration of the assessment, intervention ratio in favour of therapeutic interventions, suggests that the redesigned service supported continuity of care at a management and relational level. These crude results, in the context of an escalating and unsustainable demand on health and social care services could be interpreted as responding to the central government's policy aspirations of creating service efficiencies in efforts to contain costs within public services.

However, the empirical data within this research also reflected significant variation in discrete service performance and exposed prevailing antecedent counterproductive practices in the implementation of the service redesign. Significant inter-service variations in terms of the therapist's ability and/or capacity to assume the extended responsibilities arising from the four discrete service redesign measures were notable. Service specific variations as to the occupational therapy service's performance in assuming the extended responsibilities embodied within the 4 discrete service redesign measures manifested as an empirical indication of differences in the respective organisations underlying situational contexts and prevailing service logics. Quantifiable differences in relation to the antecedent contextual conditions for practice were observed e.g. Patient dependency profiles, practice approaches to assessment, service activity in terms of intervention. These antecedent conditions were empirically reflected in both the implementation and the outcomes of the service redesign. The detail of these service variations are outlined in chapter 4 and discussed more fully in chapters 5 and 6. However, within this concluding chapter, an emphasis is centred on the in-reach, outreach service redesign measure as the definitive measure that harnessed the potential for longitudinal models of patient care. As such, this measure was singularly capable of creating the underlying mechanistic potential to generate actions that could minimise the incidence of transitions of patient care; whilst the remaining 3 service redesign measures contributed to the cause at an informational and/or management level. From an inter-organisational whole system perspective, results illustrated that the Local Authority occupational therapists who were allocated 42.4% (14/33) of the

total patient population, completed 66.7% (22/33) of the in-reach, outreach practice arrangement; whilst their Acute based health counterparts who were allocated 30.3%,(10/33), completed 24.2% (8/33) of the patient sample total, and the Primary Care occupational therapy contingent who were allocated 27.3% (9/33), only succeeded in completing the in-reach, outreach extended patient caring responsibility in 9.1% (3/33) of the service redesign total patient population.

7.3.2. Service Redesign Outcomes: Meso Level Service Perspective

From the perspective of the service provided to patients and the outcomes arising there-in, the empirical data analysis showed that contact with patients was nominal, fragmented and largely unresponsive. Unveiling the nature, content, frequency and duration of the direct and indirect occupational therapy service activity (summarised in tables 2-6 and graphs 1-3), provided illuminating insights as to the discrete service's modus operandi pre and post service redesign. It also highlighted contradictory evidence to challenge assumptions about some of the specific performance measure results that, in isolation, could be interpreted as generating service efficacies and/or supporting the practical implementation of patient continuity of care.

The pre-existing occupational therapy practice capacity was shown to be predominantly engaged in bureaucratic organisational service systems and processes. The service activity analysis across all service sectors reflected that occupational therapy services dedicated 24.8% of the service capacity to direct patient contact; the balance being committed primarily to intra rather than inter-service administrative and ancillary activities. The dominance of the introspectively focussed service activity was evident within all occupational therapy services and the prerequisite inter-organisational information sharing and care planning systems, actions and activities to promote continuity of care were not embedded within the service structures or occupational therapy practice (Belling et al 2011). Observations suggested continuity of patient care was undermined as the service activity was circumscribed by the setting at the point it was being delivered. The reliance on synecdoche focussed the therapist's efforts inwardly to deliver on predetermined input/output service specific targets at the expense of activity not subject of governance by targets (Bevan and Hood, 2006).

Notwithstanding the sombre implications of this on the quality of the patient's transition between occupational therapy services, the quality of the care within service was also compromised. The research evidence reflected service activity patterns that were indicative of practices that resonated with the "mass processing" of patients as referred to by Lipsky (2010, pp. xii). The research data highlighted incidences where patients were either subjected to unnecessary interventions, or alternatively, did not receive therapeutic interventions where a need had been identified. All three occupational therapy service's habitual assessment and intervention practice arrangements demonstrated pre-determined mechanistic approaches to care. For example, 39.4% (13/33) of the service intervention activity within the health sector based occupational therapy services was directed to patients who were deemed as independent following assessment in the activities they subsequently received therapeutic interventions; whilst only 32.6% of the patient identified need requiring occupational therapy intervention across Acute, Primary Care and Local Authority occupational therapy services was addressed. These service specific activity patterns demonstrated established delineated service parameters which determined the nature and content of the service delivered to patients, irrespective of need.

This questionable practice resonates with the gaming behaviours outlined by LeGrand (2003) and Seddon (2008) in their accounts of behaviours observed within organisational structures pursuing performance targets. The empirical evidence within this research coincides with their perspectives and presents a disconcerting overview of the professional practice within the respective occupational therapy services. The person centred ethos advocated by the Joint Future (2000) policy initiative at the macro level is subverted in practice at the micro-agential occupational therapist level (Lipsky, 2010). Moreover, the occupational therapist's approach at the micro level contravened their professional responsibilities in terms of their duty of care to the patient. Occupational therapy services to the patient were illustrated to be adversely circumscribed and the profession's efficacy in terms of promoting patient independence was, contrary to the systematic review claims, fundamentally debilitated from both within and across occupational therapy services. Discontinuity of patient care persisted despite the introduction of service redesign

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

measures developed to promote continuity of patient care. The initial epistemic reflection of the occupational therapy services achieving the service redesign objective of minimising patient transitions of care is undermined by the empirical findings reflecting the discrete results of the stratified continuity of care measures at the informational, management and relational levels. These results reflect service specific variances in the implementation of the service redesign measures. The divergence in the service performance results suggested underlying antecedent situational contexts that both facilitated and constrained the implementation of the service redesign measures. The extent to which patient continuity of care aspirations were realised within the respective Acute, Primary Care and Local Authority services raises questions as to not only the validity of the initial interpretation of the empirical analysis which decreed the service redesign a success, but also as to why the observed variance in performance occurred.

7.3.3. Service Redesign Outcomes: Structural Conditioning Influences

The research evidence presents patterns to suggest that the divergence in the occupational therapists' performance in the implementation of the service redesign measures were influenced by the situational mechanisms generated from their respective organisational context in which they practiced. As a result, the relative alignment (or misalignment) of the pre-existing organisational archetype to the policy directive aspirations (embodied within the continuity of care service redesign measures), determined the distribution of power in terms of the cultural and structural hegemony in favour of the Local Authority situational context. This influenced the action formation strategies adopted by the therapists in context, which in turn, determined the activation of transformational mechanisms to being that of a morphostatic or morphogenetic nature. The situational logics of protection, compromise, elimination and opportunism (Archer 1995) motivated different forms of strategic action, but the predominant overtly evidenced situational logic operating within all three occupational therapy services was that of protection. The situational logic was predicated on preserving the individual and collective therapist's vested interests within their respective organisational situational context; albeit the underlying social properties within the Health and Local Authority contexts differed and a distinct delineation between the cognitive reasoning and practice capacity

Chapter 7: Conclusion - Reflections and Recommendations for Future Research emerged between the Health based occupational therapists and those employed within the Local Authority organisational context.

Occupational therapists within the health based Acute and Primary Care services were confronted with conditional influences embodied within the service redesign measures which generated incompatibilities with their pre-existing structural and cultural relations; whilst the Local Authority's occupational therapists' pre-existing situational influences were aligned with the conditional influences arising from the introduction of the service redesign measures. In the implementation of the service redesign measures, the occupational therapists drew on their pre-existing interpretive schemes to make sense of the practice and system change being introduced (Giddens 1984). The therapist's interpretive schemes were embedded within their respective social structures and produced the moral codes of sanctioned norms within context. The tension for the Health based Acute and Primary Care occupational therapists arose from multiple perspectives. Each of the four service redesign measures introduced conflicted with the pre-existing organisational specific practice norms at stratified interdependent levels. In contrast, the Local Authority occupational therapists' experience of implementing the four service redesign measures was relatively unproblematic. The established interpretive schemes were allied to the concepts and approach promoted within the service redesign measures and the system changes introduced were marginal. As such, the service redesign measures did not pose the incompatibilities to the Local Authority occupational therapists as experienced by their Health based counterparts.

Each of the four service redesign measures individually and collectively introduced structural influences which presented the occupational therapists with different choices. These choices generated mechanisms with causal powers to either reproduce or transform the situational context in which they operated. The therapist's interpretations of the associated rewards or exigencies arising from the service redesign measures were juxtaposed against their vested interests in accordance with their interpretive schemes. This research exposed these as being derived from the pre-existing internal relations and dependencies the occupational therapists held with their respective organisation's systemic structures (Archer, 1995; Argyris and Schon, 1974). In efforts to preserve these relations, the

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

mechanisms activated by the health based therapists within Acute and Primary Care services illustrated an agential preference to constrain the service redesign situational influences through actions that circumvented or undermined their implementation; whilst the Local Authority occupational therapists activated mechanistic tendencies and executed actions that promoted their reproduction. Both service sectors however, applied a predominant situational logic of protection in efforts to preserve the respective service's pre-existing situational contexts and thus neither activated mechanisms which resulted in structural transformation. The rationale for the choices made by the occupational therapists was embedded within the second order emergent property of necessary complementarities as described by Archer (1995). That is, the occupational therapists pre-existing complementary internal relations with their respective organisation's systemic structure influenced the therapist's discretionary decisions in the implementation of the service redesign measures.

From the Health based Acute and Primary Care occupational therapy service's perspective, the dominance of the biomedical approach within the extended health based organisational context rendered the MoHOST as incongruent to the therapists' vested interests as a profession within the health based multidisciplinary team. The psychological and social components of the tool's design were considered superfluous to the practice and organisational norms. The MoHOST failed to resonate in practice as the tool's utility within the extended health based multidisciplinary team was perceived as inconsequential. As such, the pre-existing internal relations were not complementary. The implementation of the MoHOST effectively called for a fundamental paradigm shift within the health based occupational therapy practice arrangements which contravened the prevailing organisational practice paradigm.

Similarly, the shared I.T. and in-reach, outreach service redesign measures both served to destabilise the pre-existing communication and practice norms within the health based multi-disciplinary team context. The uni-professional application of the I.T. infrastructure severed the precursory organisational communication channel with health based multidisciplinary colleagues; whilst the in-reach, outreach practice arrangement, designed to promote relational continuity of care with the patient,

Chapter 7: Conclusion - Reflections and Recommendations for Future Research inadvertently generated discontinuity and inconsistency in intra-professional relations.

Finally, the advent of the unified management service redesign measure displaced the substantive line management structures and in effect, removed the occupational therapists' situational protective influences. Lipsky's (1980) account of the "cold war" reciprocity dynamic within the substantive management arrangements dissipated and was replaced with the introduction of an "independent" manager whose status was not reliant on honouring professional preferences. The manager's capacity to retrieve patient and service intelligence independently from the occupational therapist, through the service redesign IT developments also violated the therapists' capacity to exercise pre-existing gaming activities e.g. manipulation of the nature and flow of information to managers as a strategy to exert street level discretionary control (Bevan and Hood 2006; LeGrand, 2003; Seddon, 2008, Lipsky, 2010).

The dissonance generated from the unintended consequences of the service redesign measures revealed an inextricable reliance of the occupational therapists on the antecedent relations within their respective health based organisational contexts (Van Maanen, 1975; Wilson, 1968; Schein, 1999, 2004). The omnipotence of these situational influences were illustrated within this research as having supremacy in influencing the therapist's agency in the discretionary choices they made in practice. The compulsion of the occupational therapists to preserve their respective pre-existing professional social positions was amidst compelling empirical evidence and experiential events that generated conflicting and competing underlying mechanisms that would have supported actions to the contrary. The capacity and potential of the service redesign measures to improve the quality of patient care and amplify the professional rewards in practice were acknowledged by the therapists. These were however, on balance, relegated in the interests of alternative situationally influenced mechanistic tendencies that preserved the therapists' vested interests resulting in morphostasis.

In contrast, the situational influences from a Local Authority occupational therapy perspective generated an advantageous organisational context from which to operationalise all four service redesign measures in totality. Collectively, the

Chapter 7: Conclusion - Reflections and Recommendations for Future Research measures' conditional influences befitted the traditional perceived and actual professional role of the Local Authority occupational therapists, and as such, were complementary to the pre-existing internal relations (Archer 1995). The alignment of the pre-existing organisational archetype to the service redesign measures was predicated by central government policy directive's promoting community based action and demanding a shift in the professional and organisational paradigms of engagement with the patient from institutional to community settings and from that of "fixer" to "facilitator" (Ham et al 2012).

The Local Authority's antecedent operations were grounded in the dominant social model of care paradigm with an emphasis, and a legislative duty, on patient engagement and empowerment. The occupational therapy service's experiential exposure to an alternative to the profession's traditional medical science derived knowledge base (AOT 1968b), provided the therapists with an embedded interpretive scheme that accommodated the occupational therapy theory derived MoHOST in practice; whilst the biomedical situational influences arising from the professional training supported the implementation of the accompanying MBI ordinal scale assessment tool. These organisational compatibilities were further validated in practice by the predominance of the equipment and adaptations mode of intervention across all three service sectors. The established "specialist"⁷¹ professional role of discharging the Local Authority's legislative responsibilities⁷² in terms of the equipment and adaptations resource responded to the employing body's expectations and connected to therapist's sense of professional self.

The Local Authority occupational therapist's pre-existing practice approach's congruence with the epistemological underpinning of the MoHOST was further complemented with their familiarity with the information system in which the tool was embedded. The unified IT service redesign measure was in effect an extension of the therapist's established professional case recording arrangements. As these were integral to the Local Authority social work department's documentation systems, the pre-existing intra-organisational multidisciplinary communication

⁷¹ Local Authority occupational therapy re as specialists within the field of equipment and adaptations

⁷² Chronically Sick and Disabled Person's Act (1974)

Chapter 7: Conclusion - Reflections and Recommendations for Future Research
systems were preserved; and as a consequence, the therapist's interpretative schemes were again validated.

The conducive Local Authority situational context extended to the introduction of the unified management arrangement. Occupational therapists within the Local Authority context were au fait with a governance infrastructure that directed service activity in accordance with the service timescale standards. The pre-existing accountability structures incorporated responsibility not only to professional managers but also to political masters who questioned professional reasoning as a means to justify public money expenditure on equipment and adaptations. The scrutiny and accountability introduced within the auspices of the service redesign did not present additional demands on the therapists that could not be rationalised within their pre-existing interpretive schemes. The research findings suggest that this privileged situational context of the Local Authority based occupational therapists generated a contextual capacity for the therapists to assume the four service redesign measures in totality. The aggregated effects of the therapist's compliance with the unified practice approach, the shared IT system and the unified management arrangement resulted in the service's ability to successfully complete all in-reach, outreach service redesign measure cases allocated within the Local Authority context.

7.3.4. Service Redesign Outcomes: The Agency of Occupational Therapists.

The structural influences at the macro level of analysis e.g. Governmental targets, organisational and service priorities and governing epistemological practice approaches, provided the structural conditioning rationale for the therapists' actions. However, in accordance with Archer's (1995) process of mediation, the occupational therapists' structural conditioning was subject to their autonomous powers of reflexivity. The inherent potential of the therapists' interpretative freedom to transform the pre-existing discrete service operations was not realised as the therapists' vested interests predicated their actions to preserve the pre-existing service arrangements. This phenomenon occurred despite a universally espoused commitment to the service redesign aspirations in respect to patient continuity of care.

The disconnect between the therapists' espoused commitment and their actions in the implementation of the service redesign measures reflected the degree to which the situational influences governed their strategic actions. The discourse during these events suggested that the therapists were motivated to engage in an inter-organisational collaboration to minimise the incidence of patient transitions of care through continuity of patient care. Their participation in the development of the service redesign measures, incorporating option appraisal and option weighting exercises provided the opportunity for the profession to forge a mutuality based on a shared commitment to improving the quality of patient care. These espoused positions reflected the homogeneity and commitment, described by Lax and Sebenius (1986) as being required to transcend the discrete organisational priorities and facilitate the engagement in collaborative endeavours. This research however, illustrates the incongruence between the stated intent and the strategies and actions adopted by the health based occupational therapists in the implementation of the service redesign measures; whilst the congruence observed within the Local Authority occupational therapy service context arose from an alignment of the service redesign conceptual and epistemological principles to the pre-existing practice norms within the service. As such, the practice experience of the occupational therapists within the health sector differed substantially from the in-practice experience of the Local Authority occupational therapists.

The extent to which the structural and cultural influences, at a macro level, structurally conditioned the occupational therapist's propensity to think, feel and act in determinant⁷³ ways is legitimised within the discrete organisational social norms. In this sense, habitus is purported to be created and reproduced unconsciously (Gaventa 2003; Wacquant 2005: 316, cited in Navarro, 2006). Notwithstanding the legitimacy provided by the concept of structural conditioning and acknowledging the unconscious reproduction of behavioural patterns within specific contexts, this research also observed the reflexivity of the occupational therapists in their *conscious* structural and cultural struggles during the implementation of the service redesign measures. Further precision as to the process of mediation at the micro (action formation) reveals a theoretical explanation as to why, despite the universally espoused commitment to continuity of patient care, the occupational therapists', as

⁷³ Archer (1995): Non deterministically yet non the less with directionality

Chapter 7: Conclusion - Reflections and Recommendations for Future Research agents with autonomous powers, conceded to their respective intra-organisational norms; and secondly, on the premise that all three occupational therapy services adopted a situational logic of protection, why the discrete service redesign outcomes present such divergent results.

The former paradox is the subject of the seminal work of Argyris and Schon (1974) who assert that there are important differences between the meanings created when people espouse their views and when they act them out. The scholar's theory would contend that the inconsistency observed within this research occurred as a consequence of the service redesign revealing, and bringing into focus, the pre-existing practice and system errors e.g. practice anomalies, service inefficiencies and discontinuity in patient care. The "mixed messages" between the occupational therapists' espoused position and the actual position demonstrated through the observed action within Acute and Primary Care services was formed as part of the therapists' defence strategy to the perceived personal threat induced by the introduction of the service redesign measures. The conflict between the therapists' governing variables (interpretative schemes) and the explicit exposure of the erroneous consequences of their actions within the context of the service redesign provided the therapists with the opportunity to consciously consider and reflect on the disconnect between what they espoused and what they enacted (Robinson and Lai, 2006).

Health based occupational therapists within this research expressed a sense of being overwhelmed by the expectations of the service redesign as their interpretative schemes, defined as governing variables by Argyris and Schon (1974), were challenged. The therapist's values, assumptions, theories, beliefs concepts, rules, attitudes, routines, practice norms and skills were exposed and questioned in the implementation of the service redesign. Emotive responses that reflected feelings of incompetence and professional ineptness were evidenced within the research analysis. The professional distress, loss, anxiety and frustration illustrated within this research concurred with the finding of Schultz's (2012) study on the professional consequences of strategic actions that promote continuity of patient care. The therapists' actions in response to being confronted with these personally intimidating situations, reflected model 1 behaviours such as non

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

compliance in the implementation of the MoHOST, duplicity in the service's documentation practice, self-directed, circumscribed practice in the in-reach and outreach development and antagonistic actions to discredit and immobilise the unified management measure. These model 1 behaviours are representative of Argyris and Schon's (1974) concept of single loop learning.

However, contrary to Usher and Bryant's (1989), assertion that single loop learning strategies are predicated on the assumption that the underlying frameworks are correct, the health based occupational therapists within this research acknowledged the systemic errors in pre-existing practice arrangement and organisational systems. The introduction of the service redesign measures, designed to inject alternative situational influences to support the occupational therapists to exert their agency in the discretionary choices made and engage in double loop learning actions were thwarted. The allure of preserving the pre-existing situational relations, as a means to defend their vested interests in terms of protecting their sense of personal competence, overshadowed the introduction of the measures to address the detected practice and system errors. The occupational therapists' sense of competence, self-confidence and self-esteem were dependent on their Model 1 theories in use (Argyris, 1992). Thus, structural conditioning constrained the agential capacity of the therapists to engage in double loop learning, as the structural influences shaped the context from which the therapists interpreted meaning. Altruistic interests were suspended as the therapists' discretionary choices were made to evade personal and professional loss, in acknowledgement that the consequences of their actions would perpetuate the system and the practice errors detected.

The Local Authority occupational therapist's experience of implementing all four service redesign measures was that which confirmed the therapists' governing variables as the therapists' espoused theories were congruent with their theories-in-use (Argyris and Schon, 1974). Paradoxically, the synergy experienced between the therapists' espoused theories and their theories-in-use supported the continuation of habitual practice norms without heightening the therapists' consciousness in practice. The Local Authority occupational therapists' Model 1 interpretative scheme was not challenged in the implementation of the four service redesign measures.

Consequently, the therapists were not required to question their governing variables and engage in individual reflective inquiry. No modification in the therapists' theory-in-use was necessary as the therapists' governing variables were validated and their professional sense of competence was maintained within the context of the service redesign.

In the absence of any material discrepancy between the therapists' espoused theories and theories-in-use, the levels of dissonance experienced were limited and, in accordance with Argyris and Schon's (1974) theory, the catalyst for double loop learning was absent. Although the resulting model 1, single loop strategies were successful in realising the service redesign aspiration, this was context specific and aligned to the pre-existing structural influences. Inherent risks and unintended consequences arose from the Local Authority based occupational therapists being insulated from experiencing incompatibilities in the implementation of service redesign. Within their privileged situational context, the therapists engaged in a situational logic of protection in efforts to maintain their situational advantage in the preservation of their vested interests. Practice deviations from Local Authority occupational therapy service practice norms, which were perceived as unacceptable e.g. hospital ward based activity, were circumvented or ostracised.

Archer (1995) cautions these behaviours discourages innovation and over time, entrenches agential cognition and action in unproductive patterns that are void of intellectual elaboration. The therapists' actions to preserve the socio-cultural uniformity within the Local Authority context was authenticated within the auspices of the service redesign. The emergence of the structural and cultural morphostatic tendencies were self-reinforcing, as the efficacy of this strategy in meeting the central government Joint Future (2002) policy objectives (embedded within the service redesign) were perceived as credible. However, other unintended consequences arising from the inter-organisational practice experience generated a destabilising influence on the inter-organisational relations between the therapists from the different service sectors. Local Authority occupational therapists' observations of their health based colleagues' practice resulted in unfavourable judgements about their competence. Underlying generative mechanisms of distrust and disrespect emerged, resulting in cultural friction and the erosion of inter-

Chapter 7: Conclusion - Reflections and Recommendations for Future Research organisational relations (McMurray, 2007; Huxham and Vangen, 2005). Local Authority based occupational therapists expressed concerns as to the future of partnership working. The mutuality, collective will and milieu of trust advocated as a prerequisite to collaborative ventures by March and Olsen (1989) were undermined and the in-practice experience generated adverse situational influences for future organisational collaborative endeavours.

7.3.5. Service Redesign Outcomes: Implications for Partnership Working

Partnership working within the auspices of the Health and Social Care policy framework under study aims to transform public services. The emphasis is on providing a legislative, policy and governance framework at a macro level that engenders a context for transformational change at the meso and micro levels. This research illustrated that all three occupational therapy service's engagement in the service redesign change programme resulted in morphostasis whereby services, and practice there-in, did not transform substantively. Questions arise to the inferred assumption that members within the same professional discipline; albeit within different organisational contexts, would have an epistemological advantage in collaborative endeavours. The professional aspirations declared by Blom Cooper(1989), College of Occupational Therapy (2002) and Joint Futures(2000) are challenged by the findings within this research. Irrespective of the therapist's origins, all three services demonstrated actions intended to preserve their vested interests. The divergence between the occupational therapist's experience of the service redesign and the outcomes are posited to be as a result of the conditioning influences of the emergent powers arising from the therapist's situational context as opposed to the agential redefinition of structural forms within that context. The interpretative freedom/discretionary powers exercised by the profession to preserve the pre-existing organisational specific structural and cultural norms within this research had a particular prohibitive bearing on transformational change. The implications are significant to realisation of partnership working aspirations as the occupational therapists activated underlying generative mechanisms that curtailed the production of new action strategies that had the potential to enable learning and development (Argyris). In their deliberations and actions to preserve the pre-existent social systems, the occupational therapists engaged in single loop learning, model I action strategies. The resulting defensive behaviours, emerging distrust, self-fuelling

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

processes and escalating error detected within this research are, in accordance with Argyris and Schon's (1974) theory, symptomatic of individuals using Model I, single loop strategies.

These agential interactions not only reproduced the interpretative schemes embedded within the pre-existing social structures within the discrete occupational therapy services but activated underlying mechanisms that adversely altered the situational context for future collaborative endeavours. Heightening the occupational therapist's consciousness as to the practice and system differences between the services, in the implementation of the service redesign measures, destabilised the pre-existing social ties and created tensions that caused disharmony, confusion and conflicts of interests (Goodwin et al 2004; Huxham and Vangen 2005). Trust and respect were eroded as therapists witnessed, and unfavourably judged, differences in the inter-service occupational therapy practice norms. The initial espoused mutual commitment to the promotion of patient continuity of care dissipated in favour of the therapist's vested interests in the preservation of their pre-existing social positions within their respective organisational contexts.

The prerequisite reciprocity to collaboration, as defined by Thomson and Perry (2006), was both undermined at a structural level and circumvented at an agential level. The contingent formal inter-organisational partnership agreement to engage in reciprocal undertakings in the implementation of the 4 service redesign measures was paradoxically frustrated by the alignment of these with the Local Authority occupational therapy service's situational context. The resulting hegemony in favour of the Local Authority context resulted in an imbalance in the reciprocal rights of the occupational therapists in practice. Whilst the Health based personnel were called to repeatedly compromise and relinquish their structural and cultural norms in the implementation of the service redesign, the Local Authority occupational therapy service activity did not require substantive change. As a consequence, the opportunity for the therapists to engage in the social interaction that gives reciprocal exchanges meaning through the cyclical process of negotiation and compromise was not afforded within the context of the service redesign (Powell, 1990; Lewis, 2008; Axelrod 1984). However, contrary to the assertions by Hardy 1985 and Hay 2002, the Health based occupational therapists did not submit to the dominance of

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

the Local Authority partner. The mutually beneficial interdependencies between the occupational therapy services that Powell (1990) asserts is required for organisations to collaborate was absent. The pre-existing operational links between the respective occupational therapy services were centred on transitioning patients between services and, as such, the pre-existing interdependencies between the respective services were limited. The service redesign was introduced as an isolated, uni-professional programme of change within three discrete occupational therapy services and was not embedded within the extended organisational structures. Within this context, the occupational therapists' affiliation was to their respective pre-existing organisational structures as the impetus for change, borne from the need to secure scarce resources in terms of skills, expertise and funding to achieve the collective policy objective were not explicit.

Notwithstanding the structural influences generating mechanistic tendencies towards morphostasis, this research did observe illustrations of agential elaboration within the Primary Care and Local Authority service sectors. Whether or not the occupational therapist's preliminary synchronic reflective enquiry had the potential to be embedded and extended, not only in terms of changes within their actions, but also ultimately in the values that govern their theories-in-use, is unknown due to the limitations of the service redesign implementation period. The diachronic perspective was, as a result, not within the scope of this research. The recursive concatenations of the therapists' interactions could not be evaluated over time. As a consequence the extent of any structural elaboration arising from the measures introduced through the service redesign could not be determined. Time however underscored the reality of the collaborative venture to promote patient continuity of care, as the complexity of creating authentic inter-dependencies between the occupational therapy services required the therapists time to resolve social dilemmas. These dilemmas arose from the emerging conflicting and competing generative mechanisms stimulated by the introduction of the service redesign measures.

Just as structural conditioning influenced the therapists' preponderance to engage in single loop learning strategies as a means to resolve these dilemmas, the aggregated agential cognition predisposed the organisational capacity for learning to

Chapter 7: Conclusion - Reflections and Recommendations for Future Research that of O-I learning systems. The reverberating interplay of agency and structure, immersed in single loop and O-I learning strategies and systems, as observed within the auspices of this research, culminated in a professional and organisational context that promoted collaborative inertia. Collaborative inertia, synonymous with the state of morphostasis, was not conducive to transformational change within the Acute, Primary Care and Local Authority occupational therapy services. The evidence within this research reflects the findings and assertions of previous scholars (Meschi 1997, Ring and Van de Ven 1994) in illustrating the constraining consequences of collaborative inertia in realising the collaborative advantage potential of partnership working.

7.4. Contribution to Theory, Research and Practice within Occupational Therapy

This PhD research evaluated the outcomes of a practice and system service redesign of occupational therapy services that was implemented during the timeframe of October 2006 to March 2010. Despite the passage of time, this thesis' contribution to the theoretical understanding of organisational change within a policy context which promotes partnership working between Acute, Primary Care and Local Authority occupational therapy services, continues to be relevant. The enactment of the Public Bodies (Joint Working) (Scotland) Act 2014 secures the thesis relevance within the current policy context, whilst the relevance of this research evaluation from a professional perspective is indicated by the recent works of MacGregor (2015) and Best (2017). Their studies indicate that the profession of occupational therapy continues to be tested by the challenges of integration. The introduction of a critical realist approach to the analysis of a service redesign centred on promoting patient continuity of care at an informational, management and relational level serves to methodologically enrich the analysis. By maintaining the ontological differentiation between structure and agency, this approach analytically differentiates between the conditions of action as separable from the action itself, thereby facilitating the analysis and evaluation of their interplay at stratified levels of reality. In this way, insight into the conditioning power of structure vis a vis the discrete reflexive power of agency offers the profession of occupational therapy within public services the means of exploring the complex implications of partnership working.

The primary considerations defined within this research are presented under the headings of unveiling the epistemic and ontic fallacy; authenticity: the incongruence of antecedent perceptions, statements of intent and action; the allure of succumbing to structural and cultural conditioning; the temporality of social transformation and the counterintuitive nature of unintended consequences.

7.4.1. Unveiling the Epistemic and Ontic Fallacy (Limitations in understanding a social situation from a quantitative perspective to the exclusion of a qualitative perspective, and vice versa).

From a critical realism paradigm, which considers all knowledge as being fallible, this research's triangulated mixed methodological design was grounded in abductive reasoning to observe and interpret the results from different conceptual perspectives. Quantitative methods were adopted to explore the phenomena at an empirical event level of reality; whilst qualitative approaches were assumed to explore the hermeneutic dimension.

The findings within this research exposed some of the fallibility within both the observed and the perceived. From an epistemological perspective, the preliminary evaluation of the service redesign results, informed by the quantitative tracking methodology, indicated a degree of success in achieving the service redesign objective of minimising patient transitions of care. Associated quantitative indicators of success included the observed reduction in the number of occupational therapists engaged in a patient's single episode of care, the reduction in patient length of stay within service and the reconfiguration of service delivery in favour of therapeutic interventions.

The epistemic fallacy assumes that ontological assumptions about service efficacies arising from the service redesign can be made from this epistemological perspective. However, supplementary quantitative and qualitative research findings introduce results that challenge these assumptions. The extended data sets reflect that Acute, Primary Care and Local Authority occupational therapy services engage in service centric self-fuelling processes. This creates an inefficient inter-service context that fundamentally questions the value of the occupational therapy service

Chapter 7: Conclusion - Reflections and Recommendations for Future Research to patient care. Similarly, any ontological assumptions deduced from the observed differences in the respective occupational therapy services' capacity to assume the extended remits arising from the continuity of patient care measures may also prove erroneous.

In the process of abduction and retroduction, the analysis within this research unveiled the situational logic within all three services was that of protection. Furthermore, all three occupational therapy services were shown to have activated underlying mechanisms to generate morphostatic influences. As such, the Local Authority occupational therapy service's ability to assume the extended duty of care in totality, where their health counterparts were not, was demonstrated to be as a result of the service redesign's alignment to the Local Authority's pre-existing practice paradigm and operational systems. In effect, the observed difference in the performance of the occupational therapists did not occur as a consequence of the Local Authority occupational therapy services undergoing agential, cultural or structural elaboration, as may have been concluded from a research methodological design that did not include the cognitive and social mechanisms by which knowledge was produced within this research.

7.4.2. Authenticity: The Incongruence of Antecedent Perceptions,

Statements of Intent and Action. (The inconsistency of what people say they believe, what people say they will do and what people actually do)

The intractability of seeking truths and actionable knowledge within the social systems under study were explicated within this research. The considerations extended beyond the dynamic intricacies of the mutually influencing relationships between the occupational therapists to that which was intrinsic to the individual therapist's cognitive reasoning. The findings within this research illustrated an incoherence between the occupational therapists' perception of the antecedent context for change, their espoused commitment to the aspirations of the service redesign and the profession's actions in the subsequent implementation of the 4 service redesign measures. The plausibility as to their assertions in respect to matters concerning their substantive role and function, the service outcomes for patients and the pre-service redesign service facilitators and constraints were, in the

Chapter 7: Conclusion - Reflections and Recommendations for Future Research
absence of empirical evidence to the contrary, resounding. The incongruity between the espoused and actual however, especially within the Health sector, presented a fallacy which served to create a professional tension that influenced the occupational therapists' defensive reasoning in the implementation of the service redesign. The subsequent specific challenges to the therapists' interpretative schemes emerged with the introduction of the discrete service redesign measures and converged to reinforce the defensive mindsets.

The collaborative aims became rhetorical despite being developed in collaboration with the occupational therapists and couched in terms of the profession's homogeneity in respect of patient care. The occupational therapists' actions became orientated towards preserving their self-interests through gaming activities which distorted the transformational potential of the service redesign measures. The continued circumscribed engagement in the implementation, of the service redesign measures however, preserved a façade of a continued commitment. The therapists' discourse during this time veiled the therapists' intent and although not always explicit appeared, at times, to be beneath or beyond the occupational therapists' conscious awareness.

7.4.3. The Allure of Succumbing to Structural and Cultural Conditioning.

(Sticking to what is known and continuing to do it in the same way, when there are options for change and change is known to be needed)

Chapter 6 within this thesis provides an explanatory overview of the dualistic interplay of agency and structure in the implementation of the service redesign measures. The stratified research findings at the macro, meso and micro levels reflected the omnipotence of the pre-existing situational influences on the occupational therapists' discretionary powers in context. The occupational therapists' governing interpretative schemes within Acute, Primary Care and Local Authority occupational therapy services were illustrated as being situationally embedded. The research findings demonstrated that these structured the occupational therapists' reactions to the generative influences arising from the 4 service redesign measures. The therapists' interpretation as to the implications of these in terms of the perceived benefits or penalties were shaped by the extent to

Chapter 7: Conclusion - Reflections and Recommendations for Future Research

which these influences were aligned (or misaligned) to the therapists' situationally constructed vested interests. The extent to which the service redesign measures destabilised the occupational therapists' habitual ways of knowing and ways of being, influenced the level of dissonance experienced by the therapists.

Divergent social trends were observed between the therapists variously situated. The Local Authority occupational therapy service's situational norms resonated with the service redesign measures which reaffirmed their interpretative schemes; whilst their Health based counterparts experienced exigencies arising from variables which conflicted with their interpretive schemes. Irrespectively, the vested interests, embedded within the social positions held by the occupational therapists within all three service sectors predisposed the emerging situational logic of protection observed within this research. The associated sense of competence obtained from the therapist's affiliation with their respective organisational practice paradigm and system norms was a principal motivation in influencing the occupational therapists' agency. The situational influences injected from the introduction of the service redesign measures were juxtaposed against the established pre-existing social forms.

Within the Local Authority context, the occupational therapists actions were intent on maintaining the equilibrium experienced in practice; whilst the Health based occupational therapists' actions, which aimed to circumvent or eradicate, were activated in efforts to regain control in efforts to preserve their vested interests. The fundamental difference experienced by the Health based occupational therapy services, as observed within this research, related to the obstructions generated by the service redesign measures. These obstructions manifested as practical issues that impinged on daily practice within the areas of assessment, intervention, documentation and communication. The personal costs associated with addressing the experienced exigencies within the Health sector e.g. professional loss in terms of social position and sense of competence were deemed intolerable. On balance, the countervailing perceived personal benefits in preserving the pre-existing situational norms e.g. social position, sense of competence, and stability, were compelling.

However, in making these discretionary judgements, the therapists diminished their epistemological commitment to the continuity of patient care aspirations embodied within the service redesign. The espoused altruistic concerns relating to patient care were not evident in the observed actions of the occupational therapists. The systematic and enduring nature of the therapist's vested interests were exemplified within this research as being resistant to change. Despite the acknowledged compelling empirical evidence that illustrated the systemic failings in respect to patient care, the occupational therapists were resolute in exercising their discretionary powers to preserve the stability and kudos afforded within the pre-existing situational contextual arrangements.

7.4.4. The Temporality of Social Transformation

(Social change requires time to form and embed before optimum results can be realised)

The perception of change and temporal alteration within this research was limited to the time period dedicated to the phased implementation of the service redesign. Time as the action period to accommodate transformational change from the diachronic dimension within the realms of the complex programme of change under study was deficient. The limitation within this analysis is that the structural properties appear conflated because they are presented as having supremacy in determining social interaction. In accordance with Archer's morphogenetic theory (1995), the drawback of making agency dependent upon structure (downward conflation), or indeed vice versa (upward conflation) is that it removes the capacity for the dualistic interplay of agency and structure and renders the process of conceptualising social stability and change inept. Although, every effort was made to reflect the duality in the interaction, the change analysed within this research was limited to the course of action observed within the service redesign timescale. It did not provide sufficient time for trust and confidence to be built through member interaction and guided experiential learning. The agential elaboration potential was arguably as a consequence not realised and as a result the structural and cultural elaboration prerequisites to transformational change was not accomplished. In conclusion, the poignancy in this realisation is set against the political compulsion to reflect tangible partnership working results quickly through the introduction of successive policy initiatives over the last 3 decades. The fundamental miscalculation seems to the

Chapter 7: Conclusion - Reflections and Recommendations for Future Research
insufficient time afforded for these strategies to embed, undermining the realisation of their true transformational potential and invalidating any evaluation from a diachronic perspective.

7.4.5. The Counterintuitive Nature of Unintended Consequences

(Best laid plans with positive outcomes can also result in parallel unexpected and undesirable outcomes that work against the intended objective)

The occupational therapists were situationally positioned within a differentiated situational context in which the hegemony was unintentionally balanced toward the Local Authority context. Assumptions that the inherent shared professional knowledge base translated into a universal skill set that could assume the extended responsibilities arising from the service redesign measures, or at least the foundations to learn the new skills, was misplaced. Occupational therapists engaged in strategic actions that required discretionary judgements either to protect the perceived advantages or to eradicate or circumvent the perceived disadvantages within the situational context of the service redesign under study. The causal powers arising from these actions collectively resulted in a range of unintended consequences that were contraindicative to partnership working and the service redesign aspirations of patient continuity of care.

The interconnecting and reverberating generative influences resulting in the observed unintended consequences were multifaceted and stratified, manifesting as dynamic social entities that transcended the micro, meso and macro levels. These related to issues of inter-organisational professional distrust, compromised patient care, service inefficiencies and a circumscribed capacity for individual and organisational learning. The unintended consequences in respect to the emerging issue of distrust between the occupational therapists inter-organisationally were that they generated a spurious situational context for collaborative working for the future. This outcome represented a retrograde step to the pre-existing reciprocal partnership working arrangements and is reminiscent of the network failures described by Goodwin et al (2004).

Exposing the nature of the compromised patient care within the occupational therapy service generated professional consternation, resulting in an inflated defensive reaction by members of the profession. Professional decisions were executed on erroneous grounds in what Argyris and Schon (1974) describes as a face-saving effort to preserve their sense of competence and professional self. The ramifications of these decisions on patient care were adversely affected as the occupational therapists readjusted their practice, lowering expectations of themselves and the quality of service (Lipsky 2010). The inefficiencies in patient care were compounded by the occupational therapists' defensive behaviours, which also generated the unintended consequence of surreptitious service inefficiencies arising from duplicate activity. These arose as a result of the occupational therapists exercising their autonomous discretion to maintain the pre-existing service systems in parallel to those introduced within the service redesign as a means of preserving their structurally conditioned vested interests.

Finally, the occupational therapists' defensive behaviours predisposed tendencies toward single loop, Model I behaviours as described by Argyris and Schon (1974). These perpetuated behavioural routines that prevented new solutions from being discovered and stifled innovation. The ramifications for learning were significantly circumscribed as the therapists and their employing organisations were trapped by previous learning experiences (Levitt and March, 1998). The unintended consequence of the occupational therapists' defensive behaviours was to weaken the potential of realising the aspirations of patient continuity of care as part of the partnership agenda.

7.5. Considerations for Future Practice and System Development within Occupational Therapy Services

On reflecting on the complexities of measuring outcomes arising from service developments, it is judicious to restate fundamental epistemological and ontological considerations. Partnership working is fraught with the spectrum, interdependency and interplay of structural and agentic variables that energise and constrain within a stratified context. Variations across the micro, meso and macro dimensions are influenced by variations in the other dimensions. The transcendental nature of reality renders our knowledge as partial and provisional and as a consequence, the notion of causality as mere patterns of regularity are, in accordance with the critical realism

Chapter 7: Conclusion - Reflections and Recommendations for Future Research paradigm, misconceived. Critical realism theorising denotes the notion of causality as powers and expresses identified patterns of regularity as tendencies. These considerations have significant implications in respect to the implementation and evaluation of programmes of social change. Notwithstanding the intellectual and practical challenges of the mixed methodological research design, the value of applying mixed methods guided by critical realism methodological principles facilitates the development of more robust meta-inferences. In undertaking a critical realist evaluation of social change, as was the subject of this research, no methodological blueprint is available nor appropriate. However, the experience of undertaking this research has heightened my conscious awareness as to the need to consider a number of fundamental elements in such undertakings. This includes the following:

- 1) The relations between the agential, structural and cultural properties as discrete but interrelated entities.
- 2) The interpretations of those relations by relevant social actors; and the congruence of these vis a vis interpretations from alternative data sources.
- 3) The *actual* motivations, intentions and degree of interpretative freedom social actors have within discrete situational contexts.
- 4) The chasm between the social actors' antecedent levels of competence vis a vis the requirements of the intended programme of social change.
- 5) The temporal nature of actions and results, and the need to differentiate and incorporate synchronic and diachronic dimensions in the implementation and evaluation of social programmes of change.
- 6) The unintended consequences of actions and the subsequent effects of those intended and unintended actions on agential, structural and cultural properties and relations

7.6. Recommendations for Future Research

This research explored and presented a preliminary understanding of the agential, structural and cultural variables and relations associated with a programme of social change within an occupational therapy service. During this process a number of potential areas for future research were identified and, although centred on the profession of occupational therapy, would arguably be applicable to other public service disciplines. These include the following:

- Explore and delineate between the generative powers associated with structural influences vis a vis cultural influences that give explanatory purchase on the relativity of each on agential action.
- Explore methods to deconstruct double loop learning strategies into single loop practical operational measures as a stratified approach to the implementation of complex programmes of social change.
- Explore the distribution of power in terms of allocative (material) and authoritative (control of others' behaviours) resources in influencing the agential cognitive reasoning and action within programmes of social change.
- Explore and develop conceptual change management frameworks that focus on agential elaboration as a measure of sustainable change.
- Explore the reciprocal dynamics between agents and their managers to identify underlying generative mechanisms that perpetuate skilled incompetence within the workforce.

Further research utilising critical realism approaches within the field of occupational therapy is advocated. The research paradigm provides ontological depth, promotes abstract thinking and generates more precise explanations to the area under study. This is of particular utility in the context of the emerging complexities arising from the legislative and policy changes to promote integrated working arrangements between Health and Social Care, as has been reflected in this research. The imperative for the profession is to galvanise the inherent potential of occupational therapy through concerted strategic and operational measures to modify the profession's interpretative schemes in accordance with the central government policy objectives. Research to develop a richer understanding of the "real" causality of effective action is required to realise the aspirations of partnership working developments, such as patient continuity of care at the informational, management and relational levels.

References

- ABRAHAM, A., 2011. *Care and Compassion? Report of the Health Service Ombudsman*. London: The Stationery Office.
- ADSW, 2011. *An Evidence Base for the Delivery of Adult Services*, Association of Directors of Social Work. Edinburgh.
- AIT-HOCINE, N. and DOBSON, E., 2013. *Health and Social Care Practice and System Redesign Evaluation Report*. Hamilton: Unpublished South Lanarkshire Council.
- AIT-HOCINE, N., DOBSON, E., FORSYTH, K., MCCLYMONT, J. and MOULD G., 2008. *SWITCH Partnership Baseline Evidence and Service Redesign Planning Report*. Edinburgh: Unpublished Joint Improvement Team Scottish Government.
- ALBERTI, G., 2009. *A Review of the Procedures for Emergency Admission and Treatment, and Process Against the Recommendation of the March Healthcare Commission Report*. London: HMSO.
- ALLIANCE, 2013. *Health and Social Care in Scotland: Integration or Transformation?* s.l.: Alliance.
- ARCHER, D. and CAMERON, A., 2012. *Collaborative Leadership: Building Relationships, Handling Conflict and Sharing Control*. 2nd 2013 ed. Abington: Routledge.
- ARCHER, M. and TRITTER, J., 2000. *Rational Choice Theory: Resisting Colonisation*. London: Routledge.
- ARCHER, M., 1995. *Realist Social Theory: The Morphogenetic Approach Realist Social Theory*. Cambridge: Cambridge University Press.
- ARCHER, M., 1996. *Culture and Agency: the place of culture in social theory*. Cambridge: Cambridge University Press.
- ARCHER, M., 2003. *Structure, Agency and the Internal Conversation*. Cambridge: Cambridge University Press.
- ARCHER, M., 2007. *Making our Way through the World*. Cambridge: Cambridge University Press.
- ARCHER, M., 2010. Morphogenesis versus structuration: on combining structure and action. *The British Journal of Sociology*. vol. 61, no.1, pp. 225-252.
- ARGYRIS, C. and SCHÖN, D., 1974. *Theory in Practice: Increasing Professional Effectiveness*. San Francisco: Jossey-Bass.
- ARGYRIS, C. and SCHÖN, D., 1978. *Organizational Learning: A Theory of Action Perspective*. Reading: Addison-Wesley.
- ARGYRIS, C. and SCHÖN, D., 1996. *Organizational Learning II: Theory, Method and Practice*. 2nd ed. Boston: Addison-Wesley.

- ARGYRIS, C., 1980. *Inner contradictions of Rigorous Research (Organizational and occupational psychology)*. New York: Academic Press.
- ARGYRIS, C., 1982. *Reasoning, Learning and Action: Individual and Organizational*. San Francisco: Jossey-Basse.
- ARGYRIS, C., 2004. *Reasons and Rationalizations: The Limits of Organizational Knowledge*. Oxford: Oxford University Press.
- ARKSEY, H. and KNIGHT, P. T., 1999. *Interviewing for Social Scientists*. London: Sage.
- ASSOCIATION OF OCCUPATIONAL THERAPISTS, 1968b. *An outline of the syllabus of the course leading to the diploma*. London: British Legion Press.
- AUDIT COMMISSION, 2000. *The way to go home: rehabilitation and remedial services for older people*. London: Audit Commission.
- AUDIT SCOTLAND, 2011. *Review of Community Health Partnerships*. Edinburgh: The Accounts Commission.
- AUDIT SCOTLAND, 2015. *Health and Social Integration*. Edinburgh: The Accounts Commission.
- AUDIT SCOTLAND, 2016. *Changing models of health and social care*. Edinburgh: The Accounts Commission.
- AXELROD, R., 1984. *The Evolution of Cooperation*. New York: Basic Books.
- BALINT, M., 1957. *The Doctor, His Patient and the Illness*. London: Pitman Medical Publications.
- BARDACH, E., 1998. *Getting Agencies to Work Together: The Practice and Theory of Managerial Craftmanship*. Washington DC: Brookings Institution Press.
- BARLEY, S. R. and TOLBERT, P. S., 1997. *Institutionalization and Structuration: Studying the Links between Action and Institution*. [Online] [Viewed 3 October 2013]. Available from: <http://digitalcommons.ilr.cornell.edu-articles>.
- BARTLETT, J., 2009. *At your service: Navigating the future market in health and social care*. London: Demos .
- BATESON, G., 1972. Steps to an Ecology of Mind. Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology. San Francisco: Jason Aronson Inc..
- BBC, 1999. *UK Politics: What is the Third Way?*. London: BBC.
- BEMELMANS-VIDEC, M., RISTN, R. and VEDUNG, E., 1997. *Carrots, stick and sermons: policy instruments and their evaluation*. New York: Transaction Publishers.
- BELLING, R., WHITTOCK, M., MCLAREN, S., BURNS, T., CATTY, J., JONES, I.R. and WYKES, T., 2011. Achieving Continuity of Care: Facilitators and Barriers in Community Mental Health Teams. *Implementation Science*. [Online] [Viewed 17

January 2013]. Available from
<http://www.implementationscience.com/content/6/1/23>

BEST, S., 2017. Facilitating integrated delivery of service across organisational boundaries: Essential enablers to integration. *British Journal of Occupational Therapy*. vol. 80, no. 5, pp. 302-309

BEVAN, G. and HOOD, C., 2006. What's Measured is What Matters: Targets and Gaming in the English Public Healthcare System. *Public Administration*. August, vol. 84, no. 3, pp. 517-538.

BHASKAR, R., 1975. *A Realist Theory of Science*. York.

BHASKAR, R., 1978. *A Realist Theory of Science*. Hassocks: Harvester Press.

BHASKAR, R., 1979. *The Possibility of Naturalism: A Philosophical Critique of the Contemporary Human Sciences*. Brighton. Sussex: Harvester Press.

BHASKAR, R., 1989. *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*. London:Verso.

BIRCKMAYER, J.D. and WEISS, C.H., 2000. Theory-Based Evaluation in Practice: What Do We Learn? *Evaluation Review*. August, vol. 24, no.4, pp. 407-431

BIRD, S.M., COX, D., FAREWELL, V.T., GOLDSTEIN, H., HOLT, T. and SMITH, P.C., 2005. Performance Indicators: Good, Bad and Ugly. *Journal of the Royal Statistical Society*, October, vol. 168, no. 1, pp.1-27.

BLAIKIE, N. H. W., 1991. A critique of the use of triangulation in social research. *Quality and Quantity*. Vol. 25, no. 2, pp.115-136.

BLOM-COOPER, L., 1989. *Occupational Therapy - An Emerging Profession in Health Care*. London: Duckworth.

BONIFACE, G., FEDDEN, T., HURST, H., MASON, M., PHELPS, C., REAGON, C. and WAYGOOD, S., 2008. Using theory to underpin an integrated occupational therapy service through the Canadian model of occupational performance. *British Journal of Occupational Therapy*. vol. 71, no.12, pp. 531-39.

BONIFACE, G., MASON, M., MACINTYRE, J., SYNAN, C. and RILEY, J., 2013. The effectiveness of local authority social services' occupational therapy for older people in Great Britain: a critical literature review. *British Journal of Occupational Therapy*. December, vol. 76, no.12, pp. 538-547.

BOSANQUET, N.K. and KRUGER, D., 2003. *Strong Foundations: Building on NHS Reforms*. London: Centre for Policy Studies Publications.

BOULTON, G., 2012. *Integrated care: implementation issues for 'countries in transition'*. San Marino: Igitur publishing.

BOURDIEU, P., 1977. *Outline of a Theory of Practice*. London: Cambridge University Press.

- BOURDIEU, P., 1984. *Distinction: A Social Critique of the Judgement of Taste*. illustrated, reprint ed. Boston: Harvard University Press.
- BOYNE, J.A. and CHEN, A.A., 2006. *Performance Targets and Public Service Improvement*. Oxford: Oxford University Press.
- BROOKS, I., 2003. *Organisational Behaviour: Individuals, Groups and Organisations*. 2nd ed. Essex: Pearson Education Edinburgh Gate.
- BROOM, A. and WILLIS, E., 2007. Competing paradigms and health research. In: *Researching health: Qualitative, quantitative and mixed methods*. London: Sage, pp. 16-31.
- BRYMAN, A., 2001. *Social Research Method*. Oxford: Oxford University Press .
- BRYMAN, A., 2004. Qualitative research on leadership: a critical but appreciative review. *The Leadership Quarterly*. December, vol. 15, no. 6, pp. 729-769.
- CAERS, R., DU BOIS, C., JEGERS, M., DE GIETER, S., SCHEPERS, C. and PEPERMANS, R., 2006. Principal-agent relationships on the stewardship-agency axis. *Non-profit Management and Leadership*. September, vol. 17, no. 1, pp. 25-47.
- CALDWELL, R., 2006. *Agency and Change: Rethinking Change Agency in Organizations*. London: Routledge.
- CALDWELL, R., 2011. *Leadership and Learning: A Critical Reexamination of Senge's Learning Organization*. London: Springer Science + Business Media, LLC.
- CAMERON, A., LART, R., BOSTOCK, L. and COOMBER, C., 2012. Factors that promote and hinder joint and integrated working between health and social care services. *Social Care Institute for Excellence*.
- CAMERON, A., LART, R., HARRISON, L., MACDONALD, G. and SMITH, R., 2000. *Factors Promoting and Obstacles Hindering Joint Working: A Systematic Review*. Bristol: School for Policy Studies.
- CAMPBELL, J. L., 2005. *Where do we stand? Common mechanisms in organizations and social movements research*. Cambridge: Cambridge University Press.
- CARLSON, M., SHAN-PIN, F., ZEMKE, R. and CLARK, F., 1996. A Meta-Analysis of the Effectiveness of Occupational Therapy for Older Persons. *American Journal of Occupational Therapy*. February, vvol. 50, no. 2, pp. 89-98.
- CARLSSON, S.A., 2003. Advancing Information Systems Evaluation (Research): A Critical Realist Approach. *Electronic Journal of Information Systems Evaluation*. vol. 6, no. 2, pp. 11-20.
- CLARKE, A., 1999. *Evaluation Research: An Introduction to Principles, Methods and Practice*. London: Sage.
- COHEN, L. and MANION, L., 1994. *Research methods in Education*. 4th ed. London: Routledge.

- COHEN, M.D. and SPROULL, L.S., 1991. Editors' introduction to the special issue on organizational learning. *Organization Science*, 2(1st).
- COHEN, M.D. and SPROULL, L.S., 1991. *Organizational Learning*. London: Sage Publications.
- COLEMAN, E.A. and BOULT, C., 2003. Improving the Quality of Transitional Care for Persons with Complex Care Needs. *The American Geriatrics Society Health Care Systems Committee*. April, vol. 51, no. 4, pp. 556-557.
- COLEMAN, E.A. and BERENSON, R.A., 2004. Lost in transition: Challenges and Opportunities for Improving the Quality of Transitional Care. *Annals of Internal Medicine*. vol. 141, pp. 533-536.
- COLEMAN, E.A., 2003. Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Care Needs. *Journal of the American Geriatrics Society*. vol. 51, pp. 549-555.
- COLEMAN, J.S., 1986. Social Theory, Social Research and a Theory of Action. *The American Journal of Sociology*. vol. 91, no. 6, pp. 1309-1335.
- COLEMAN, J.S., 1990. *Foundations of Social Theory*. Cambridge: Harvard University Press.
- COLIN-THOME, D., 2009. *A Review of Lessons Learnt for Commissioners and Performance Managers Following the Healthcare Commission Investigation*. London: HMSO.
- COLL, R. K. and CHAPMAN, R., 2000. Choices of Methodology for Cooperative Education. *Asia-Pacific Journal of Cooperative Education*. vol. 1, no. 2, pp. 1-12.
- COLLEGE OF OCCUPATIONAL THERAPISTS, 2002. *From interface to integration: a strategy for modernising occupational therapy services in local health and social care communities; a consultation*. London: College of Occupational Therapy
- COLLEGE OF OCCUPATIONAL THERAPISTS, 2010. *Reablement: the added value of occupational therapists (Position Statement)*. London: College of Occupational Therapy
- COLLEGE OF OCCUPATIONAL THERAPISTS, 2012. *Integration of Adult Health and Social Care in Scotland – Consultation response*. London: College of Occupational Therapy
- COLLEGE OF OCCUPATIONAL THERAPISTS, 2016. *Occupational therapy terminology supporting occupation-centred practice*. London: College of Occupational Therapy
- COLLIN, C., WADE, D.T., DAVIES, S. and HORNE, V., 1988. The Barthel ADL Index: a reliability study. *Int. Disabil. Stud.* vol. 10, no. 2, pp. 61–63.
- COLLINS, H.M., 1985. *Changing Order: Replication and Induction in Scientific Practice*. London Beverly Hills: Sage Publications.

- COLLINS, H.M., 1990. *Artificial Experts: Social Knowledge and Intelligent Machines*. Cambridge, Massachusetts: MIT Press.
- CORNWELL, J.M. LEVENSON, R.,SONOLA, L. and POTELIAKHOFF., 2012. Continuity of care for older hospital patients: A call for action. London:King's Fund.
- CORRIGAN, P., 2002. Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly*. vol. 73, no. 3, pp. 217-228.
- COTTER, J.J., SMITH, W.R. and BOLING, P.A., 2002. Transitions of care: the next major quality improvement challenge. *British Journal of Clinical Governance*. vol. 7, no. 3, pp. 198-205.
- COURTY, P. and MARSCHKE, G., 2004. An Empirical Investigation of Gaming Responses to Exploit Performance Incentives. *Journal of Labor and Economics*. vol. 22, no.1, pp. 23-56.
- COUSINS, C., 2002. Getting to the "truth": Issues in contemplating qualitative research. *Australian Journal of Adult Learning*. vol. 42, pp. 192-204.
- CREEK, J., 2003. *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists.
- CRESWELL, J.W., FETTERS, M.D. and IVANKOVA, N.V., 2004. Designing a mixed methods study in primary care. *Annals of Family Medicine*. vol. 2, no. 1, pp. 7-12.
- CRESWELL, J.W. and PLANO CLARK, V.L., 2006. *Designing and Conducting Mixed Methods Research Paperback*. Thousand Oaks London: Sage Publications .
- CRESWELL, J.W. and PLANO CLARK, V.L., 2007. *Designing and Conducting Mixed Methods Research*. Thousand Oaks, CA: Sage.
- CRESWELL, J.W., 2003. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. Thousand Oaks CA: Sage.
- CURRY, N. and HAM, C., 2010. *Clinical and service integration: the route to improved outcomes*, London: King's Fund.
- DANERMARK, B., EKSTROM, M., JAKOBSEN, L. and KARLSSON J.C., 2002. *Explaining Society: Critical Realism in the Social Sciences*. Abingdon UK: Routledge.
- DE BRUIJIN, H., 2007. *Managing Performance in the Public Sector*. London: Routledge.
- DEMING, W. E., 1986. *Out of the Crisis*. Cambridge : Cambridge, Mass.
- DENZIN, N.K. and LINCOLN, Y.S., 2005. *The SAGE Handbook of Qualitative Research*. London: Sage Publications.
- DEPARTMENT OF HEALTH., 1997. *New NHS: Modern, Dependable*. Edinburgh: HMSO.
- DEPARTMENT OF HEALTH., 1998. *Modernising Social Services: Promoting Independence, Promoting Protection, Raising Standards*. Edinburgh: HMSO.

DEPARTMENT OF HEALTH (DH), 2007. *Putting people first: a shared vision and commitment to transformation of adult social care*, s.l.: Department of Health.

DEWING, J., 1992. A Critique of the Barthel Index. *British Journal of Nursing*. vol. 1, no.7, pp. 325-329.

DICKINSON, H., 2006. The evaluation of health and social care partnerships: an analysis of approaches and synthesis for the future. *Health and Social Care in the Community*. vol. 14, pp. 375-383.

DOBSON, F., 1999.hansard, 297(7 July), Column 642

DOBSON, P. J., 2002. Critical realism and information systems research: why bother with philosophy? *Information Research*. vol. 7, no. 2, pp. 1-12.

DOBSON, P.J., 2012. Critical realism and IS research: some methodological implications. *Research methodologies, innovations and philosophies in software systems engineering and information systems*. pp. 63-68.

DONALDSON, M.S., 2001. Continuity of Care: A Reconceptualization *Medical Care Research and Review*. vol. 58, no.3, pp. 255-290.

DOLPHIN, T., 2009. The Scale of the Challenge. In: OPPENHEIM.C., and DOLPHIN. T, ed.. *Opportunities in an Age of Austerity Smart ways of dealing with the UK's fiscal deficit*. London: Institute for Public Policy Research, pp. 13-17.

DRIVER, S. and MARTELL L., 2000. Left, Right and the third way. *The Policy Press*. vol. 28, no. 2, pp. 147-161.

DUROSE, C., 2011. Revisiting Lipsky: Front-Line Work in UK Local Governance. *Political Studies*. vol. 59, no. 4, pp. 978-995.

EAKIN, P., 1993. The Barthel Index: Confidence Limits. *British Journal of Occupational Therapy*. vol. 56, no.5, pp. 184-185.

ECCLES, A., 2008. Single shared assessment: the limits to 'quick fix' implementation. *Journal of Integrated Care*. vol. 16, no.1, pp. 22-30.

EDWARDS, D. 2010. The Model of Human Occupation: 30th anniversary special edition (Editorial). *British Journal of Occupational Therapy*. vol. 73, no. 11, pp. 497

EDWARDS, P. K., O'MAHONEY, J. and VINCENT, S., 2014. *Studying Organizations using Critical Realism A Practical Guide*. 1st ed. Oxford: Oxford University Press.

EL ANSARI, W., PHILLIPS, C.J. and HAMMIE, M., 2001. Collaboration and partnerships: Developing the evidence base. *Health and Social Care in the Community*. July, vol. 9, no. 4 pp. 215-227.

ELLINS, J., GLASBY, J., TANNER, D., MCIVER, S., DAVIDSON, D., LITTLECHILD, R., SNELLING, I., MILLER, R., HALL, K. and SPENCE, K., 2012. *Understanding*

and Improving Transitions of Older People: A user and carer centred approach. Final Report. National Institute for Health Research.

ELSTER, J., 1989. Social Norms and Economic Theory. *The Journal of Economic Perspectives*. vol. 3, no. 4, pp. 99-117.

ELSTER, J., 2007. *Explaining social behavior. More nuts and bolts for the social sciences*. Cambridge: Cambridge University Press.

EVANS, T. and HARRIS, J., 2004. Street-Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion. *British Journal of Social Work*. vol. 34, no. 6, pp. 871-895.

EVANS, A., 2006. *Discretion and Street-Level Bureaucracy Theory: A Case Study of Local Authority Social Work*. Warwick: University of Warwick, School of Health and Social Studies.

FAKHOURY, W.F. and WRIGHT, D., 2004. A National survey of approved social workers in the UK Information, communication and training needs. *British Journal of Social Work*. vol. 36, pp. 663-675.

FESTINGER, L., 1957. *A theory of cognitive dissonance*. Evanston IL: Row & Peterson.

FORSYTH, K., PARKINSON, S., KIELHOFNER, G., KRAMER, J., MANN, L.S., DUNCAN, E.A.S., 2011. The measurement properties of the model of human occupation screening tool and implications for practice. *New Zealand Journal of Occupational Therapy*. vol. 58, no.2, pp.5-13.

FOSS, N.J. and NIELSEN, B.B., 2010. *Researching Collaborative Advantage: Some Conceptual and Multi-Level Issues*, s.l.: s.n.

FOSS, N.J. and NIELSEN, B.B., 2012. Researching Multilevel Phenomena: The Case of Collaborative Advantage in Strategic Management. *Journal of CENTRUM Cathedra*. vol. 5, no.1, pp. 11-23.

FRANCIS, R., 2010. *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009*. London: The Stationery Office.

FREEMAN, G. and HUGHES, J., 2010. *Continuity of care and the patient experience*, London: The King's Fund.

FREEMAN, G., WEAVER, T., LOW, J., DE JONGE, E. and CRAWFORD, M., 2002. *Promoting Continuity of Care for People with Severe Mental Illness whose needs span primary, secondary and social care. A multi-method investigation of relevant mechanisms and contexts*, s.l.: Queen's Printer and Controller of HMSO 2002.

FRICKE, J. and UNSWORTH, C.A., 1996. Inter-rater reliability of the original and modified Barthel Index, and a comparison with the Functional Independence Measure. *Australian Occupational Therapy Journal*. vol. 43, pp. 22-29.

GABEL, B., 2012. *Book review: Street Level Bureaucracy: Dilemmas of the Individual in Public Services*: PA 715. San Francisco: San Francisco State University.

- GAVENTA, J., 2003. *Power after Lukes: a review of the literature*. Brighton: Institute of Development Studies.
- GIDDENS, A., 1984. *The Constitution of Society*. Cambridge: Polity Press.
- GIDDENS, A., 1998. *The Third Way. The Renewal of Social Democracy*. Cambridge: Polity .
- GILMORE, S. and WARREN, S., 2007. Themed article: Emotion online: Experiences of teaching in a virtual learning environment. *Human Relations*. vol. 60, no. 4, pp. 581-607.
- GLASBY, J., DICKINSON., H. and MILLER, R., 2011. *All in this together? Making best use of health and social care resources in an era of austerity*. Birmingham: HSMC.
- GLENDINNING, C. and MEANS, R., 2004. Rearranging the deckchairs on the Titanic of long-term care – is organizational integration the answer? *Critical Social Policy*. vol. 24, no. 4, pp. 435. Sage Publications
- GOODRICH, J. and CORNWELL, J., 2008. *Seeing the person in the patient The Point of Care review paper*. London: The King's Fund.
- GOODSHIP, J., JACK, K., GUMMERSON, M., LATHLEAN, J. and COPE, S., 2004. Modernising Regulation or Regulating Modernisation? The Public, Private and voluntary Interface in Adult Social Care. *Public Policy and Administration*. vol. 19, no. 2, pp. 13-27.
- GOODWIN, N., 2008. "Are networks the answer to achieving integrated care?". *Journal of Health Services Research and Policy*. vol. 13, no. 2, pp. 58-60.
- GOODWIN, N., PECK, E. and Freeman, T., 2004. *Managing Across Diverse Networks of Care: Lessons from Other Sectors*, s.l.: NCCSDO.
- GRAY, B., 1989. *Collaborating: Finding Common Ground for Multiparty Problems*. 1st ed. London: Jossey-Bass Ltd.
- GREIFFENHAGEN, C. and SHARROCK, W., 2008. Where do the limits of experience lie? Abandoning the dualism of objectivity and subjectivity. *History of the Human Sciences*. vol. 212, no. 3, pp. 70-93.
- GUBA, E.G. and Lincoln, Y.S., 1994. Competing Paradigms in Qualitative Research. In: N.K.DENZIN and Y.S.LINCOLN, ed. *Handbook of qualitative research*. Thousand Oaks, CA: SAGE. pp. 105-177.
- GUILFOYLE, S., 2013. *Intelligent Policing: How Systems Thinking Methods Eclipse Conventional Management Practice*. Devon: Triarchy Press.
- GULLIFORD, M., NAITHANI, S. and Morgan, M., 2006. What is "continuity of care?". *Journal of Health Services Research and Policy*. vol. 11, no. 4, pp. 248-250.
- HABERMAS, J., 1978. *Knowledge and Human Interests*. London: Heinemann Educational.

HAGEDORN, R., 1997. *Foundations for Practice in Occupational Therapy*. London: Churchill Livingstone.

HAGGERTY, J.L., REID, R. J., FREEMAN, G.K., STARFIELD, B.H., ADAIR, C.E. and Mckendry, R., 2003. Continuity of care: a multi-disciplinary review. *British Medical Journal*. vol. 327, no. 7425, pp. 1219-1221.

HAGLUND, L., and KJEELLBERG, A., 1999. A Critical Analysis of the Model of Human Occupation. *Canadian Journal of Occupational Therapy*. vol. 66, no. 2, pp.102-8.

HAM, C., DIXON, A. and BROOKE, B., 2012. *Transforming The Delivery of Health and Social Care*. London: King's Fund.

HAMDAN, A., 2009. *Reflexivity of Discomfort in Insider-Outsider Educational Research*. *McGill Journal of Education*. vol. 44, no. 3, pp. 377–404.

HAMMERSLEY, M., 2009. Why Critical Realism fails to justify critical social research. *Methodological Innovations*. Vol. 4, no. 2, pp.1-11

HAMNETT, M., PORTER, D., SINGH, A. and KUMAR, K., 1984. *Ethics, politics and international social science research*. Honolulu: University Hawaii Press.

HAMPTON, P., 2004. *Reducing administrative burdens: effective inspection and enforcement*. London: HM Treasury.

HARDY, C., 1985. The Nature of Unobtrusive Power. *Journal of Management Studies*. vol. 22, no. 4, pp. 384-399.

HARDY, C., PHILLIPS, N., LAWRENCE., 1998. Distinguishing Trust and Power in Interorganizational Relations: Forms and Facades of Trust. In LANE. C., and BACHMANN, ed. *Trust within and between organisations*. Oxford: Oxford University Press, pp.64-87

HARRIS, J., SUN, L. and ADAMS, A., 2009. *Requirements Analysis for an e-Government System to Support Multi-Organisational Collaborative Groups*. [Online] [viewed 20 May 2012]. Available from: <https://www.researchgate.net/publication/228796399>.

HAWKINS, P., 1991. The spiritual dimension of the learning organisation. *Management Education and Development*. vol. 22, no. 3, pp. 166-181. Role of Boundary Spanners 2010.

HAY, C., 2002. Political Analysis. A Critical Introduction. In Williams, P. *Collaborative Futures: New Insights from Intra and Inter-Sectoral Collaborations*. 2010. University of Birmingham.

HAYEK, F.A., 1948. *Individualism and Economic Order*. Chicago: University of Chicago Press.

HEDLUND-DE WIT, N., 2013. Towards a Critical Realist Integral Theory[online] [viewed 15 April 2013] Available from: www.academia.edu/46661222/Towards_a_Critical_Realist_Theory

- HEALY, M. and PERRY, C., 2000. Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research: An International Journal*. vol. 3, no. 3, pp. 118-126.
- HEATON, J., CORDEN, A. and PARKER, G., 2012. 'Continuity of care': a critical interpretative synthesis of how the concept was elaborated by a national research programme. *International Journal of Integrated Care*. vol. 12, no. 2.
- HEDSTROM, P. and SWEDBERG, R., 1998. *Social Mechanisms: An Analytical Approach to Social Theory*. Cambridge: Cambridge University Press.
- HEDSTROM, P. and YLIKOSKI, P., 2010. Causal Mechanisms in the Social Sciences. *Annual Review of Sociology*. vol. 36, pp. 49-64.
- HEIFETZ, R. and LINSKY, M., 2004. When Leadership Spells Danger. *Educational Leadership*. vol. 61, no. 7, pp. 33-37.
- HEINRICH, C.J. and MARSCHKE, G.R., 2010. Incentives and Their Dynamics in Public Sector Performance Management Systems. *Journal of Policy Analysis and Management*. vol. 29, no. 1, pp. 183-208.
- HEINRICH, C. J., 2008. Advancing Public Sector Performance Analysis. *Applied Stochastic Models in Business and Industry*. vol. 24, no. 5, pp. 373-389.
- HERNES, G., 1998. Real Virtuality. In: P. HEDSTROM & R. SWEDBERG, ed. *Social mechanisms: An analytical approach to social theory*. Cambridge, UK: Cambridge University Press. pp. 74-101.
- HILL, A.P. and FREEMAN, G.K., 2011. *Promoting Continuity of Care in General Practice: Policy Paper*. Royal College of General Practitioners.
- HOGAN, K. and ORME, S., 2000. Measuring disability: a critical analysis of the Barthel Index. *British Journal of Therapy and Rehabilitation*. vol. 7, no. 4, pp. 163-167.
- HOOD, C., 2006. Gaming in Targetworld: The Targets Approach to Managing British Public Services. *Public Administration Review*. vol. 66, no. 4, pp. 515-521.
- HOUSTON, S., 2001. Beyond social constructionism: critical realism and social work. *British Journal of Social Work*. vol. 31, pp. 845-861.
- HOWE, D., 1991. *Knowledge, power and the shape of social work practice*. In: DAVIES M ed. *The Sociology of Social Work*. London: Routledge, pp. 202-220
- HUDSON, B. and HENDWOOD, M., 2002. The NHS and social care: the final countdown? *The Policy Press*. vol. 30, no. 2, pp. 153-166.
- HUDSON, B., 1993. Michael Lipsky and street level bureaucracy a neglected perspective. In: *The Policy Press A Reader*. New York: Harvester Wheatsheaf.
- HUDSON, B., 2011. All that glitters. *Journal of Integrated Care*. vol. 17, no. 2, pp. 4-12.
- HUME, D., 1739. *A Treatise of Human Nature*. London: John Noon.

- HUMPHRIES, R. and Curry, N., 2011. *Integrating Health and Social Care, Where Next?* London: The King's Fund.
- HUXHAM, C. and VANGEN, S., 2000. Ambiguity, complexity and dynamics in the membership of collaboration. *Human Relations*. vol. 53, no. 6, pp. 771-806.
- HUXHAM, C. and VANGEN, S., 2004. Doing things collaboratively: realising the advantage or succumbing to inertia. *Organizational Dynamics*. vol. 33, no. 2, pp. 190-201.
- HUXHAM, C. and VANGEN, S., 2005. *Managing to Collaborate: the theory and practice of collaborative advantage*. London: Routledge.
- HUXHAM, C., 1996. Advantage or inertia: Making collaboration work. In: *The new management reader*. London: Routledge, pp. 238-254.
- JACKSON, P.M., 2011. Governance by Numbers: What Have We Learned Over the Past 30 Years? *Public Money and Management*. vol. 3, no. 1, pp. 13-26.
- JACOBS, R., SMITH, P. and GODDARD, M., 2004. Measuring Performance: an examination of composite performance indicators. *CHE Technical Paper Series no. 29*. York: University of York.
- JAKIMOW, T., 2008. Answering the critics: The potential limitations of the knowledge agenda as a practical response to post-development critiques. *Progress in Development Studies*. vol. 8, no. 4, pp. 311-323.
- JEFFCOTT, S.A., IBRAHIM, J.E. and CAMERON, P.A., 2009. Resilience in healthcare and clinical handover. *BMJ Health and Safety The international journal of healthcare improvement*. vol. 18, no. 4, pp. 256-260.
- JENNINGS, P.L., 2015. *Hidden Treasures: the contribution of Critical Realism to Evaluation*. Coventry: The University of Warwick Business School.
- JESSOP, B., 2004. Critical Semiotic Analysis and Cultural Political Economy. *Critical Discourse Studies*. vol. 1, no. 2, pp. 159-174.
- JOHNSON, R.B. and ONWUEGBUZIE, A.J., 2004. Mixed methods research: a research paradigm whose time has come. *Educational Researcher*. vol. 33, no. 7, pp. 14-26.
- JOINT IMPROVEMENT TEAM, 2009. Chapter 3: *The Scottish Policy Context for Partnership: Health, Social Care and Housing Partnership Working*.
- JONES, M.S., 1964. *Approach to Occupational Therapy*. 2nd Revised edition ed. University of Michigan ed. UK: Butterworth & Co Publishers Ltd.
- JORDAN, B., 2001. Tough Love: Social Work, Social Exclusion and the Third Way. *British Journal of Social Work*. vol. 31, no.4, pp. 527-546.
- JOSEPH, J.M., 1998. In Defense of Critical Realism. *Capital & Class*. vol 22, no. 2, pp.73-106
- KERR, J.R., SCHULTZ, K. and DELVA, D., 2012. Two new aspects of continuity of care. *Canadian Family Physician*. vol. 58, no. 8, pp. 442-449.

- KEAT, R. and URRY, J., 2011. *Social Theory as Science*. Boston: Routledge and Kegan Paul.
- KIELHOFNER, G., 2008. *Model of Human Occupation: theory and application*. 4th ed. Baltimore, MD: Lippincott Williams & Wilkins.
- KIELHOFNER, G., FAN, C-W., Morley, M., GARNHAM, M., HEASMAN, D., FORSYTH, Kirsty, LEE, S.W. and TAYLOR, R. R., 2010. A psychometric study of the model of human occupation screening tool (MOHOST). *Hong Kong Journal of Occupational Therapy*. vol. 20, no. 2, pp. 63-70. ISSN 15691861.
- KOHN, L. T., CORRIGAN, J. M., and DONALDSON, M. S., 2000. *To err is human: Building a safer health system*. Washington, D.C.: National Academies Press.
- KODNER, D., 2009. *All Together Now: A Conceptual Exploration of Integrated Care*. *Healthcare Quarterly*. October, vol. 13, Special Issue, pp 6-15.
- KODNER, D., SPREEUWENBERG, C., 2002. Integrated Care: Meaning, logic, applications and implications - a discussion paper. *International Journal of Integrated Care*. November, vol. 2, no. 4. DOI: <http://doi.org/10.5334/ijic.67>.
- KRAUSS, S.E., 2005. Research Paradigms and meaning making: A primer. *The Qualitative Report*. vol. 10, no. 4, pp. 758-770.
- LACEY, H., 2007. Explanatory Critique. *Dictionary of Critical Realism*. pp. 196-201. Available from: <http://works.swarthmore.edu/fac-philosophy/201>
- LANGHORNE, P., 2003. Early supported discharge: An idea whose time has come? *Comment. Stroke*. November, vol. 34, no. 11, pp. 2691-2692.
- LAUGALAND, K.A., AASE, K. and BARACH, P., 2012. Interventions to improve patient safety in transitional care - a review of the evidence. *Work*. January, vol. 4, pp. 2915-2924.
- LAX, D. and SEBENIUS, J.K., 1986. *The Manager as Negotiator: Bargaining for Cooperation and Competitive Gain*. New York: Free Press.
- LAYDER, D., 2006. *Understanding Social Theory, second edition*. London: Sage Publications.
- LEE, G., [no date]. The World of Structure and Agency, [online] [viewed 10 November 2015]. Available from: <https://www.academia.edu/>
- LE GRAND, J., 2003. *Motivation Agency and Public Policy*. Oxford: Oxford University Press.
- LEUTZ, W., 1999. Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom. *The Milbank Quarterly*. vol. 77, no. 1, pp. 77-110.
- LEVENSON, R., 2007. *The Challenge of Dignity in Care: Upholding the rights of the individual*, s.l.: s.n.

- LEVITT, B. and MARCH, J.G., 1988. Organizational Learning. *Annual Review of Sociology*. vol. 14, pp. 319-340.
- LEWIS, R.D., 2008. *Cross Cultural Communication: A Visual Approach*: Transcreen Publications.
- LINCOLN, Y.S. and Guba, E.G., 1985. *Naturalistic Inquiry*. London: Sage Publications.
- LING, T., 2000. Unpacking partnership: the case of healthcare. In: J. CLARKE, ed. *New Managerialism, New Welfare?* London: Sage.
- LIPSKY, M., 1980. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.
- LIPSKY, M., 1991. The Paradox of Managing Discretionary Workers in Social Welfare Policy. In: *The Sociology of Social Security*. Edinburgh: Edinburgh University Press.
- LIPSKY, M., 2010. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. 30th Anniversary Expanded Edition ed. New York: Russell Sage Foundation.
- LOWNDES, V. and SKELCHER, C., 1998. The Dynamics of Multi-organizational Partnerships: an Analysis of Changing Modes of Governance. *Public Administration*. vol. 76, no. 2, pp. 313-333.
- LUNA-REYES, L.F., MARTIR, S.C., ANDERSEN, D.F., PARDO, T.A., RICHARDSON, G.P. and CRESSWELL, A.M., 2007. *Emergence of the Governance Structure for information integration across governmental agencies: a system dynamics approach*. Albany, NY: Rockefeller College of public affairs and Policy University.
- MAANEN, J.V., 1975. Police Socialisation: a longitudinal examination of job attitudes in an urban police department. *Administrative Science Quarterly*. vol. 20, pp. 207-228.
- MACDONALD, E.M., 1970. *Occupational therapy in rehabilitation: a handbook for occupational therapists, students and others interested in this aspect of reablement*. London: Bailliere, Tindall & Cassell.
- MACGREGOR, S., 2015. A Mixed Methods Study of the Integration of Health and Social Care Occupational Therapy Provision: The Complexity of Change. A thesis submitted in partial fulfilment of the requirements of Glasgow Caledonian University for the degree of Professional Doctorate. Glasgow Caledonian University.
- MACKENZIE, N. and KNIPE, S., 2006. Research dilemmas: Paradigms, methods and methodology. *Issues In Educational Research*. vol. 16, no. 2, pp. 193-205.
- MAHONEY, J., 2001. Beyond correlational analysis: Recent innovations in theory and method. *Sociological Forum*. vol. 16, pp. 575-593.

- MANNION, R. and BRAITHWAITE, J., 2012. Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. *Internal Medicine Journal*. vol. 42, no. 5, pp. 569-574.
- MANSAH, M., GRIFFITH, R., FERNANDEZ, R. and CHANG, E., 2000. *Effectiveness of strategies to promote safe transition of elderly people across care settings*. Adelaide, Australia: The Joanna Briggs Institute Systematic Reviews.
- MANTHORPE, J. and ILIFFE, S., 2003. Professional predictions: June Huntington's perspectives on joint working, 20 years on. *Journal of Interprofessional care*. vol.17, no. 1, pp. 85-94.
- MANZO, G., 2007. Variables, Mechanisms and Simulations: Can the Three Methods Be Synthesized? A Critical Analysis of the Literature.
- MARCH, J. G. and OLSEN, J. P., 1989. Rediscovering Institutions: The Original Basis of Politics. In: THOMSON, A.M. and PERRY, J.L., 2006. Collaboration Processes: Inside the Black Box. *Public Administration Review*, Issue: Special Issue. pp. 20-32.
- MAXWELL, J.A. and MITTAPALLI, K., 2010. Realism as a Stance for Mixed Methods Research. In: A. Tashakkori and C. Teddlie (Eds.), *SAGE Handbook of Mixed Methods in Social and Behavioral Research*, 2nd ed. Sage Publications. pp. 145-167.
- MCADAM, D., TARROW, S., and TILLY, C., 2001. *The Dynamics of Contention*. Cambridge: Cambridge University Press.
- MCEVOY, P. and RICHARDS, D., 2003. Critical Realism: a way forward for evaluation research in nursing? *Journal of Research in Nursing*. vol. 43, no. 4, pp. 411-420.
- MCEVOY, P. and RICHARDS, D., 2006. A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Advanced Nursing*. vol. 11, no. 1, pp. 66-78.
- MCLEAN, G. and SUTTON, M., 2008. *What impact did the creation of Local Health Care Co-operatives have on indicators of practice resources and activity*. [online] [viewed 15 April 2013] Available from: <http://www.biomedcentral.com/14726963/8/104>.
- MCMURRAY, R., 2007. Our reforms, our partnerships, same problems: The chronic case of the English NHS. *Public Money & Management*. vol. 27, no. 1, pp. 77-82.
- Medical Research Council ethics and research guidance: Available from: <http://www.mrc.ac.uk/research/research-policy-ethics/>
- MERTENS, D.M., 2005. *Research Methods in education and psychology: Integrating diversity with quantitative and qualitative approaches*. 2nd ed. Thousand Oaks: Sage.
- MERTON, R.K. and Kendall, P.L., 1946. The focused interview. *The American Journal of Sociology*. vol. 51, no.6, pp. 541-557.

- MESCHI, P.X., 1997. Longevity and cultural differences of international joint ventures: Toward time-based cultural management. *Human Relations*. vol. 50, pp. 211–228.
- MEYER, M.W. and GUPTA, V., 1994. The Performance Paradox. *Research and Organizational Behaviour*. vol.16, pp. 309-369.
- MEYER, M.W. and O'SHAUGHNESSY, K., 1993. Organizational design and the performance paradox. In: R. Swedberg, ed. *Explorations and economic sociology*. New York: Russell Sage Foundation. pp. 249-278.
- MEYER, S.B. and LUNNAY, B., 2013. *The Application of Abductive and Retroductive Inference for the Design and Analysis of Theory-Driven Sociological Research*. [online] [viewed 1 April 2013] Available from: <http://www.socreonline.org.uk./18/12.html>.
- MICHELI, P. and NEELY, A., 2010. Performance measurment in the public sector in England: searching for the golden thread. *Public Administration Review*. vol. 70, no. 4) pp. 591-600.
- MILES, M. B. and HUBERMAN, A.M., 1994. *Qualitative Data Analysis*. 2nd ed. Thousand Oaks, CA: Sage Publications.
- MINGERS, J., 2004. Real-izing information systems: critical realism as an underpinning philosophy for information systems. *Information and Organisation*. vol. 14, no. 2, pp. 87-103.
- MINGERS, J., 2008. Ethics for Business: The Contribution of Discourse Ethics and Critical Realism. In: *International Association for Critical Realism*. London: King's College.
- MODELL, S., 2009. In defence of triangulation: A critical realist approach to mixed methods research in management accounting. *Management Accounting Research*. vol. 20, no. 3, pp 208-221.
- MORGAN, D.L., 1996. *Annual Review of Sociology*. Portland: Annual Reviews.
- MOUNTAIN, G., 2001. United We Stand; Divided We Fall!. *British Journal of Occupational Therapy*. vol. 64, no. 3, pp. 153-154.
- MOUNTAIN, G., 2002. "Integration: The Occupational Therapy Experience". *Journal of Integrated Care*. vol. 10, no. 2, pp. 44-48.
- MOYNIHAN, D.P., 2008. *The Dynamics of Performance Management: Constructing Information and Reform*. Georgetown: Georgetown University Press.
- NATIONAL RECORDS SCOTLAND OFFICE, 2014. *Population Projections for Scottish Areas (2012-based)*, Edinburgh: National Records of Scotland.
- NATIONAL RECORDS SCOTLAND OFFICE, 2016. *Population Projections for Scottish Areas (2014-based)*, Edinburgh: National Records of Scotland.
- NAVARRO, Z., 2006. In Search of Cultural Interpretation of Power. *IDS Bulletin*. vol. 37, no. 6, pp. 11-22.

- NEWMAN, J., 2001. *Modernising Governance*. London: Sage.
- NHS SCOTLAND., 2012. *The National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015*. Edinburgh: The Scottish Government.
- NIELSEN, R., 1993. Woodman's "I am We" triple-loop action-learning: origin and application in organization ethics. *The Journal of Applied Behavioural Sciences*. vol. 29, pp. 117-138.
- NOTOH, H., YAMADA, T., KOBAYASHI, N., YOSHIKAZU, I. and FORSYTH, K., 2013. Examining the Psychometric Properties of the Model of Human Occupation Screening Tool Japanese Version. *Hong Kong Journal of Occupational Therapy*. vol. 23, pp. 26-31.
- NONAKA, I. and TAKEUCHI, H., 1995. *The knowledge-creating company*. Oxford: Oxford University Press.
- NUTTING, P.A., GOODWIN, M.A., FLOCKE, S.A., ZYZANSKI, S.J. and STANGE, K.C., 2003. 'Continuity of primary care: to whom does it matter and when?'. *Ann Fam Med*. vol. 1, pp. 149-155.
- O'NEILL, O., 2002. *A Question of Trust*. Cambridge: Cambridge University Press.
- OSTERLOH, M. and FREY, B.S., 2000. Motivation, knowledge transfer, and organizational forms. *Organization Science* 2000. vol. 11, no. 5, pp. 538-550.
- OSTROM, E., 1990. *Governing the Commons: The Evolution of Institutions for Collective Action*. Cambridge: Cambridge University Press.
- OSTROM, E., 1998. A behavioural approach to the rational choice theory of collective action. *American Political Science Review*. vol. 92, no. 1, pp. 1-22.
- OUTHWAITE, W., 1983. Toward a realist perspective. In: G. Morgan, ed. *Beyond Method: Strategies for social research*. Beverly Hills, CA: Sage, pp. 321-330.
- PARKINSON, S., FORSYTH, K. and KIELHOFNER, G., 2006. *A user's manual for the Model of Human Occupation Screening Tool (MOHOST): (version 2.0)*. Chicago, Illinois: University of Illinois.
- PAWSON, R. and TILLEY, N., 1997. *Realistic Evaluation*. London: Sage.
- PAWSON, R. and TILLEY, N., 2004. *Realist Evaluation*. British Cabinet Office.
- PAWSON, R. and TILLEY, N., 1994. *Realist Evaluation*. London: Sage.
- PAWSON, R., 1989. *A Measure for Measures: A Manifesto for Empirical Sociology*. London: Routledge.
- PAWSON, R., 2008. Method mix, technical hex, theory fix. In: M. Bergman, ed. *Mixed Methods Research: Advances in Theory and Applications*. London: Sage.
- PERLESZ, A. and LINDSAY, J., 2003. Methodological triangulation in researching families: making sense of dissonant data. *International Journal of Social Research*. vol. 6, no. 1, pp. 25-40.

- PETCH, A., 2012. Tectonic plates: aligning evidence, policy and practice in health and social care integration. *Journal of Integrated Care*. vol. 20, no. 2, pp. 77-88.
- PETCH, A., COOK, A. and MILLER, E., 2013. *Partnership working and outcomes: Do health and social care partnerships deliver for users and carers?* s.l.: John Wiley and Sons Ltd.
- PETCH, A., COOK, A. and MILLER, E., 2005. Focusing on Outcomes Their Role in Partnership Policy and Practice. *Journal of Integrated Care*. vol. 13, no. 6.
- PETERS, G.B., 2009. The Problem with Bureaucratic Government. *The Journal of Politics*. vol. 42, no. 1, pp. 56-82.
- PFEFFER, G. and SALANCIK, G.R., 1978. *The External Control of Organizations: A Resource Dependence Perspective*. New York: Harper and Row.
- PHILLIPS, N. and BROWN, J.L., 1993. Analyzing communication in and around organizations: A critical hermeneutic approach. *Academy of Management Journal*. vol. 36, pp. 1547-1576.
- POWELL, W., 1990. Neither Market nor Hierarchy: Network Forms of Organization. *Research in Organizational Behaviour*. vol. 12, pp. 295-336.
- RAMAZANOGLU, C., 2002. *Feminist Methodology: Challenges and Choices*. Holland: Sage.
- REED, J., COOK, G., CHILDS, S. and McCormack, B., 2005. A literature review to explore integrated care for older people. *International Journal of Integrated Care*. vol. 5, no.1. DOI: Available from: <http://doi.org/10.5334/ijic.119>
- RILEY, J., 2002. Occupational Therapy in Social Services: a Missed Opportunity. *British Journal of Occupational Therapy*. vol. 65, no. 11, pp. 502-508.
- RING, P.S. and VAN DE VEN, A.H., 1994. Developmental Processes of Cooperative Interorganizational Relationships. *The Academy of Management Review*. vol. 19, pp. 90-118.
- ROBINSON, V.M.J. and LAI, M.K., 2006. *Practitioner Research for Educators: A guide to improving classrooms and schools*. Thousand Oaks, CA: Corwin Press.
- RUBIN, H.J. and RUBIN, I., 2005. *Qualitative Interviewing: The art of hearing data*. Thousand Oaks, CA: SAGE pub.
- SANDERSON, I., 2001. Performance management evaluation and learning in modern local government. *Public Administration*. vol. 79. no. 2, pp. 297-331.
- SANDFORT, J.R. and MILWARD, H.B., 2007. "Collaborative Service Provision in the Public Sector", In: Steve Cropper, Mark Ebers, Chris Huxham, and Peter Smith Ring eds., *Handbook of Inter-Organizational Relations*, Oxford University Press.
- SAULTZ, J., 2013. Defining and measuring interpersonal continuity of care. *Annals of Family Medicine*. vol. 1, pp. 134-143.
- SAYER, A., 1992. *Method in Social Science: A Realist Approach*. New York: Routledge .

- SAYER, A., 1997. Critical Realism and the Limits of Critical Social Science. *Journal for the Theory of Social Behaviour*. vol. 27. No.4, pp.473-487
- SAYER, A., 2010. Reductionism in Social Science. In: R.E. Lee, ed. *Questioning Nineteenth-Century Assumptions about Knowledge II:Reductionism*. Albany, NY: State University of New York Press, pp. 5-39.
- SCHEIN, E. H., 2004. *Organizational Culture and Leadership*. 3rd ed. San Francisco CA: Jossey-Bass.
- SCHOFIELD, J., 2004. A model of Learned Implementation. *Public Administration*. vol. 82, no. 2, pp. 283-308.
- SCHULTZ, A. K., DELVA, D. and KERR, J., 2012. *Emotional effects of continuity of care on family physicians and the therapeutic relationship*. Canadian family physician *Medecin de Famille Canadien*. vol. 58, no. 2, pp. 178-185.
- SCHUMACHER, J.G., 2005. Emergency Medicine and Older Adults: Continuing Challenges and Opportunities. *American Journal of Emergency Medicine*. vol. 23, no. 556-560.
- SCOTTISH EXECUTIVE, 2002. *The joint future group report- community care a joint future*. Edinburgh: Scottish Executive.
- SCOTTISH EXECUTIVE, 2003. *Joint Performance Information and Assessment Framework (JPIAF) – Annual Evaluation Statements, 2002-03*. Edinburgh: Scottish Executive.
- SCOTTISH EXECUTIVE, 2003. *Equipped for Inclusion: Report of the Strategy Forum: Equipment and Adaptations*. Edinburgh: Scottish Executive. Available from: <http://www.gov.scot/Resource/Doc/47102/0030337.pdf>
- SCOTTISH EXECUTIVE, 2004b. *Community Health Partnerships Statutory Guidance*. Edinburgh: Scottish Executive.
- SCOTTISH GOVERNMENT, 2013a. *HEAT Targets*. Edinburgh: Scottish Government.
- SCOTTISH GOVERNMENT, 2000. *Community Care: A joint future*. Edinburgh: Scottish Executive.
- SCOTTISH GOVERNMENT, 2002. *Community Care and Health (Scotland) Act 2002*. Available from: http://www.legislation.gov.uk/asp/2002/5/pdfs/asp_20020005_en.pdf
- SCOTTISH GOVERNMENT, 2011. *Reshaping Care for Older People: A programme for change 2011-2021*. Edinburgh: Scottish Government. Available from: <http://www.gov.scot/Resource/0039/00398295.pdf>
- SCOTTISH GOVERNMENT, 2012. *AHPs as Agents of Change in Health and Social Care: The National Delivery Plan for the Allied Health Professions in Scotland 2012-2015*. Edinburgh:Scottis Government. Available from: <http://www.gov.scot/Publications/2012/06/9095/downloads>

SCOTTISH OFFICE, 1997. Designed to Care: renewing the National Health Service in Scotland (Cm 3811). Available from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/260828/scotnhs.pdf

SCOTTISH OFFICE, 1998 Modernising Community Care: An Action Plan. Edinburgh: Scottish Office.

SCOTTISH PARLIAMENT. SPICe Briefing, 2013. *Public Bodies (Joint Working) (Scotland) Bill*. Edinburgh: The Scottish Parliament. Available from:
http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_13-50.pdf

SEDDON, J., 2008. *Systems Thinking in the Public Sector*. Axminster: Triarchy Press.

SEEBOHM, F., 1968. *The Seebohm Report*, Westminster: Department of Health.

SENGE, P.M., 2006. *The Fifth Discipline: The Art and Practice of the Learning Organization*. 2nd ed. London: Random House Business Books.

SHAH, S., VANCLAY, F. and COOPER, B. 1989. Improving the sensitivity of the Barthel Index for stroke rehabilitation. *Journal of Clinical Epidemiology*. vol 42, No. 8 pp. 703-709.

SMITH, C. and ELGER, T., 2014. Critical Realism and Interviewing Subjects. In: EDWARDS, P.K., O'MAHONEY, J. and VINCENT, S., 2014. *Studying Organizations using Critical Realism A Practical Guide*. 1st ed. Oxford University Press, pp. 109-131.

SMITH, M.L., and SEWARD, C., 2005. *Causal Theories and citizenship: Bridging the theory-data gap in Sen's capability approach*. Paris, [viewed 18 September 2012]. Available from:
https://www.researchgate.net/publication/224622633_Causal_theories_and_citizenship_Bridging_the_theory-data_gap_in_Sen%27s_capability_approach

STALKER, K., JONES, C. and RITCHIE, P., 1995. *Occupational therapy: changing roles in community care? : a report to the Social Work Services Inspectorate of The Scottish Office*, Edinburgh: Scottish Office Home and Health Department.

STEELE, G.R., 2005. Critical thoughts about critical realism. *Critical Review*. Vol. 17, no. 1, pp.133-154

STERN, R. and GREEN, J., 2005. Boundary workers and the management of frustration: A case study of two Healthy City partnerships. *Health Promotion International*. vol. 20, no. 3, pp. 269-276.

STEULTJENS, E.M.J., DEKKER, J., BOUTER, L.M., LEEMRIJSE, C.J. and VAN DEN ENDE, C.H.M., 2005. Evidence of the efficacy of occupational therapy in different conditions: An overview of systematic reviews. *Clinical Rehabilitation*. vol. 19, no. 3, pp. 247-254.

- STEWART, A., PETCH, A. and CURTICE, L., 2003. Moving towards integrated working in health and social care in Scotland: from maze to matrix. *Journal of Interprofessional Care*. vol. 17, no. 4, pp. 335-350.
- STRAUSS, A. and CORBIN, J. M., 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, CA: SAGE Pub.
- STENSAKER, I. and FALKENBERG, J. 2007. Making sense of different responses to corporate change. *Human Relations*. January, vol. 60, no.1, pp.137-177.
- SUTTON, R.I. and STAW, B.M., 1995. What Theory is Not. *Administrative Science Quarterly*. September, vol. 40, no. 3, pp. 371-384.
- TASHAKKORI, A. and TEDDIE, C., 1998. *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.
- TASHAKKORI, A. and TEDDIE, C., 2003. *Handbook of Mixed Methods in Social & Behavioral Research*. Thousand Oaks: Sage.
- THAGARD, P., 1978. The best explanation: Criteria for theory choice. *Journal of Philosophy*. February, vol. 75, no. 2, pp. 76-92.
- THIEL, S.V. and LEEUW, F.L., 2002. The Performance Paradox in the Public Sector. *Public Performance and Management Review*. March, vol. 25, no. 3, pp. 267-281.
- THOMPSON, M., 2007. Innovation in Work Practices: A Practice Perspective. *The International Journal of Human Resource Management*. vol. 18, no. 7, pp. 1298-1317
- THOMPSON, K.R., and MATHYS, N.J., 2013. It's time to add the employee dimension to the balanced scorecard. *Organisational Dynamics*. Vol. 42, no.2, pp.135-144
- THOMSON, A.M., and PERRY, J.L., 2006. Collaboration Processes: Inside the Black Box. *Public Administration Review*, Issue: Special Issue, pp. 21-32.
- TILLY, 2001. Mechanisms in Political Processes. *Annual Review of Political Science*. June, vol. 4, pp. 21-41.
- TOSEY, P., VISSER, M. and SAUNDERS, M.N.K., 2012. The origins and conceptualizations of 'triple-loop' learning: A critical review. *Management Learning*. July, vol. 43, no. 3, pp. 291-307.
- TOWNSEND, E.A. ed., 2002. *Enabling Occupation: An Occupational Therapy Perspective*. Nepean ON: Canadian Association of Occupational Therapists.
- TROCHIM, W.M., 2000. *The research methods knowledge base*. Cincinnati, OH: Atomic Dog Publishing.[online] [viewed 15 April 2013] Available from: <http://www.socialresearchmethods.net/kb/>
- TSANOS, C.S., ZOGRAFOS, K. and HARRISON, A., 2014. Developing a conceptual model for examining the supply chain relationships between behavioural

antecedents of collaboration, integration and performance. *The International Journal of Logistics Management*. vol. 25, no. 3, pp. 418-462.

TSASIS, P., EVANS, J.M. and OWEN, S., 2012. Reframing the challenges to integrated care: a complex-adaptive systems perspective. *International Journal of Integrated Care*. vol. 12, no. 5, pp. 1-11.

TURNER, B., ROJEK, C. and CALHOUN, C., 2005. *The Sage Handbook of Sociology*. London: Sage.

TURNER, A., 2002. History and Philosophy of Occupational Therapy. In: TURNER, A., FOSTER, M. and JOHNSTON, S.E, ed. *Occupational Therapy and Physical Dysfunction, Principles, Skills and Practice*. Edinburgh: Churchill Livingstone. pp. 3-24.

USHER, R. and BRYANT, I. 1989. *Adult Education as Theory, Practice and Research*. London: Routledge.

VANGEN, S. and HUXHAM, C., 2003. Nurturing Collaborative Relations Building Trust in Interorganizational Collaboration. *The Journal of Applied Behavioural Science*. vol. 39, no. 1, pp. 5-31.

VANGEN, S. and HUXHAM, C., 2003. Enacting Leadership for Collaborative Advantage: Dilemmas of Ideology and Pragmatism in the Activities of Partnership Managers. *British Journal of Management*. vol. 14, no. 1, pp. S61–S76.

VANGEN, S. and HUXHAM, C., 2006. "Achieving collaborative advantage: understanding the challenge and making it happen". *Strategic Direction*. vol. 22, no. 2, pp. 3-5.

VANGEN, S. and HUXHAM, C., 2012. The Tangled Web: Unraveling the Principle of Common Goals in Collaborations. *Journal of Public Administration Research and Theory*. vol. 22, no. 4, pp. 731-760.

VANGEN, S. and WINCHESTER, N., 2014. Managing cultural diversity in collaborations: a focus on management tensions. *Public Management Review*. vol. 16, no. 5, pp. 686–707.

WACQUANT, L., 2005. Habitus. In: J. BECKETT, and Z. MILAN, ed. *International Encyclopedia of Economic Sociology*. London: Routledge.

WANG, C.L. and AHMED, P.K., 2002. *A Review of the Concept of Organisational Learning*, Wolverhampton: University of Wolverhampton.

WARREN, P.L., 2012. Allies and Adversaries: Appointees and Policymaking Under Separation of Powers. *The Journal of Law Economics and Organization*. vol. 28, no. 3, pp. 407-446.

WEBER, K., 2006. From nuts and bolts to toolkits: Theorizing with mechanisms. *Journal of Management Inquiry*. vol. 5, pp. 119-123.

WEISS, C.H., 1998. *Evaluation: Methods for Studying Programs and Policies*. Upper Saddle River, NJ: Prentice Hall.

- WHEELER, D.J., 2000. *Understanding Variation: The Key to Managing Chaos*. Knoxville: SPS Press.
- WHEELER, D.J., 2003. *Making Sense of Data*. Knoxville: SPC Press.
- WILDING, C., 2010. Defining Occupational Therapy. In: *Occupational Therapy and Physical Dysfunction Enabling Occupation*. Edinburgh: Churchill Livingstone.
- WILEY, N., 1988. The Micro-Macro Problem in Social Theory. *Sociological Theory*. vol. 6, no. 2, pp. 254-261.
- WILKINSON, D., 1997. Whole system development: rethinking public service management. *International Journal of Public Sector Management*. vol. 10, no. 7, pp. 505-533.
- WILLIAMS, F., 1999. Good-enough Principles for Welfare. *Journal of Social Policy*. vol. 28, no. 4, pp. 667-687.
- WILLIAMS, P., 2002. The Competent Boundary Spanner. *Public Administration*. vol. 80, no. 1, pp. 103-124.
- WILLIAMS, P. and SULLIVAN, H., 2009. Faces of Integration. *International Journal of Integrated Care*. vol. 22, no. 9, pp.1-13.
- WILLMOTT H., 2005. Theorizing Contemporary Control: Some Post-structuralist Responses to Some Critical Realist Questions. *Organizations*. September, vol. 12, no. 5, pp.747-780.
- WIMPENNY, K., FORSYTH, K., JONES, C., MATHESON, L. and COLLEY, J. 2010. Implementing the model of human occupation across a mental health occupational therapy service: communities of practice and a participatory change process. *British Journal of Occupational Therapy*. June, vol. 73, no. 11, pp.507-516.
- WOLFE, A., 1997. *The two faces of social science*. In: K. ERICKSON, ed. *Sociological Visions*. Oxford: Rowman and Littlefield, pp. 31-56
- WOODWARD, C.A., ABELSON, J., TEDFORD, S. and HUTCHISON, B., 2004. What is important to continuity in homecare? Perspectives of key stakeholders. *Social Science and Medicine*. vol. 58, no. 1, pp. 177-192.
- WUISMAN, J.J.J.M.,2005. The Logic of Scientific Discovery in Critical Realist Social Scientific Research. *Journal of Critical Realism*. Vol4, no2, pp.366-394
- YERXA, E.J., CLARK, F., FRANK, G., JACKSON, J., PARHAM, D., PIERCE, D., STEIN, C. and ZEMKE, R., 1989. An introduction to occupational science: a foundation for occupational therapy for the 21st century. *Occupational Therapy in Health Care*. vol. 6, no. 4, pp. 1-17.
- ZACHARIADIS, M., SCOTT, S. and BARRETT, M., 2010. *Exploring critical realism as the theoretical foundation of mixed-method research: evidence from the economies for IS innovations*. Judge Business School working paper series, 3. Cambridge: University of Cambridge.
- ZACHARIADIS, M., SCOTT, S. and BARRETT, M., 2013. Methodological implications of critical realism for mixed-methods research. *MIS Quarterly*. vol. 37, no. 3, pp. 855-879.



Mapping Workshop Information Sheet

Welcome to our mapping workshop

Mapping Process

We will be asking you to think about the following steps of the OT service process:-

Referral	Allocation	Assessment	Intervention	Discharge/ case closure
<i>Think about:</i> Blanket	<i>Think about:</i> Self allocation	<i>Think about:</i> ADL	<i>Think about:</i> Equipment	<i>Think about:</i> D/c routes
Professional referrals	Senior/team leader ETC	Physical Neurological Cognitive	Adaptations Rehabilitation	referrals ETC
OT practitioner screened		Environment – social/physical	Education ETC	
Intake schemes ETC		Interview ETC		

NB The “*Think about*” lists are intended as examples

We will be considering each of the above steps in the OT service process in the framework of the following factors:-

Factors to consider for each section	Prompts to think about
Process	What are the O.T. service systems, what are the tasks within those system (service user pathway) Parallel Processes
Service Standards/ criteria for service	In-house or statutory standards, service criteria
Documentation	Written reports, notes, application/referral forms, prioritisation proformas, paperwork, I.T. inputs!
Communication	Verbal (face to face and phone calls) and non-verbal (i.e. emails, faxes, letters etc)
Responsibility	Who is responsible for undertaking the task and who is overseeing each task
Times	“Task Time” –How long does the task take “Wait Time”- How long does the patient/service user have to wait between tasks

We will be using colour coding for each factor in the framework to allow us to understand maps at a later to date to create electronic examples. PLEASE TAKE NOTE OF THE FOLLOWING COLOUR CODES.

Factors	Colour Codes
Process	Blue
Service Standards/ criteria for service	lilac
Documentation	yellow
Communication	pink
Responsibility	green
Times	orange



Mapping Workshop Information Sheet

Summary & Evaluation Process

Once we have considered each section using the above framework, we will reflect and complete a summary/evaluation off the whole process.

We will be asking the following questions:-

Summary/ Evaluation Questions
<ul style="list-style-type: none"> • How many steps are in the process? • How long does the whole process take? • What steps take longest? • Is there any batching in the process? • What steps 'add value' to patient/service user? • What steps 'add value' to the process? • What steps are waste? (e.g. rework loops, duplication) • What are the parallel processes and what is impact of these? • Are there activities completed that are process driven rather than patient/service user led? • What are problems for patient and staff?

Time Scales for Workshop

We will be keeping to the following time scales to ensure all information is gathered to build maps of OT services within the workshops.

Activity/section	Time
Introduction	10am – 10.20am
Referral section	10.20am – 10.50am
Allocation section	10.50am – 11.10am
Assessment section	11.10am – 12.10pm
Lunch	12.10pm – 12.40pm
Intervention section	12.40pm – 1.40pm
D/c, Case closure section	1.40pm – 2.10pm
Mapping Summary/ Evaluation	2.10pm – 4pm

Thank you for your contribution



Mapping Workshop Information Sheet

Welcome to our mapping workshop

Mapping Process

We will be asking you to think about the following steps of the OT service process:-

Referral Routes	Frequency of Referrals	Health & social care interface	Good Practice & challenges
<i>Think about:</i> D/c routes Verbal Written Fax Email	<i>Think about:</i> Where does referral go? How often do you refer to other services?	<i>Think about:</i> Direct access to technician Stock lists Satellite stock Prescriptive referrals	<i>Think about:</i> What works well? What help your practice with Clients? What good be improved?

NB The “*Think about*” lists are intended as examples

We will be considering each of the above steps in the OT service process in the framework of the following factors:-

Factors to consider for each section	Prompts to think about
Process	What are the O.T. service systems, How does one system feed into another OT service? Parallel Processes
Service Standards/ criteria for service	In-house or statutory standards, service criteria
Documentation	Referral forms, case notes etc
Communication	Verbal (face to face and phone calls) and non-verbal (i.e. emails, faxes, letters etc)
Responsibility	Who is responsible for undertaking the task and who is overseeing each task
Times	“Task Time” –How long does the task take “Wait Time”- How long does the patient/service user have to wait between tasks

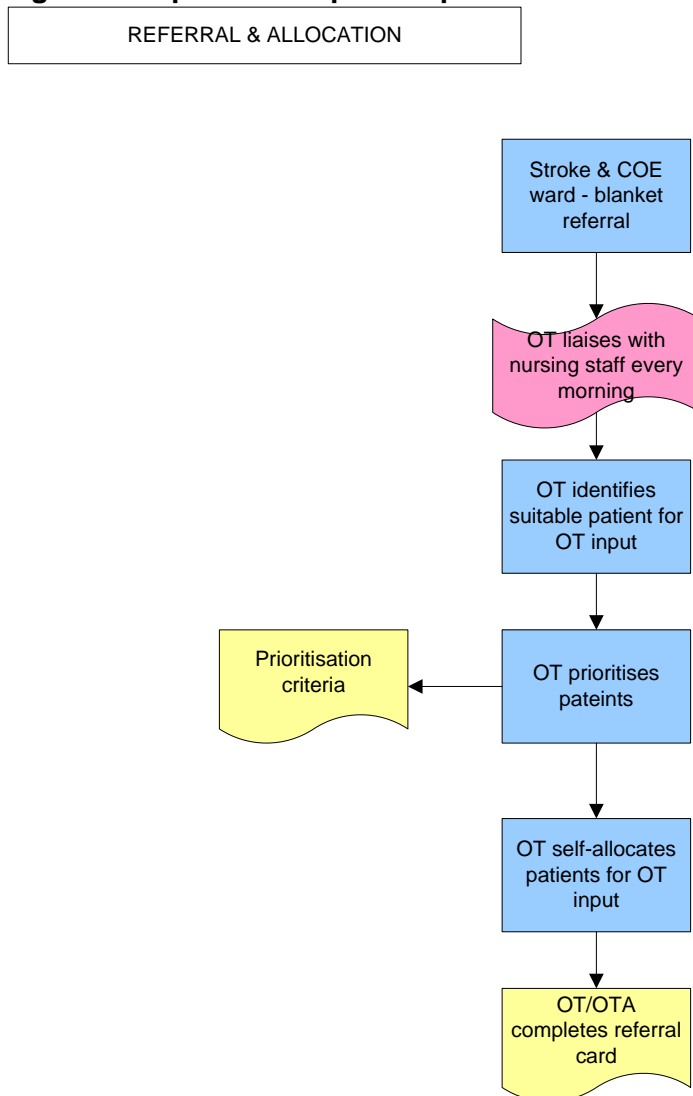
We will be using colour coding for each factor in the framework to allow us to understand maps at a later date to create electronic examples. PLEASE TAKE NOTE OF THE FOLLOWING COLOUR CODES.

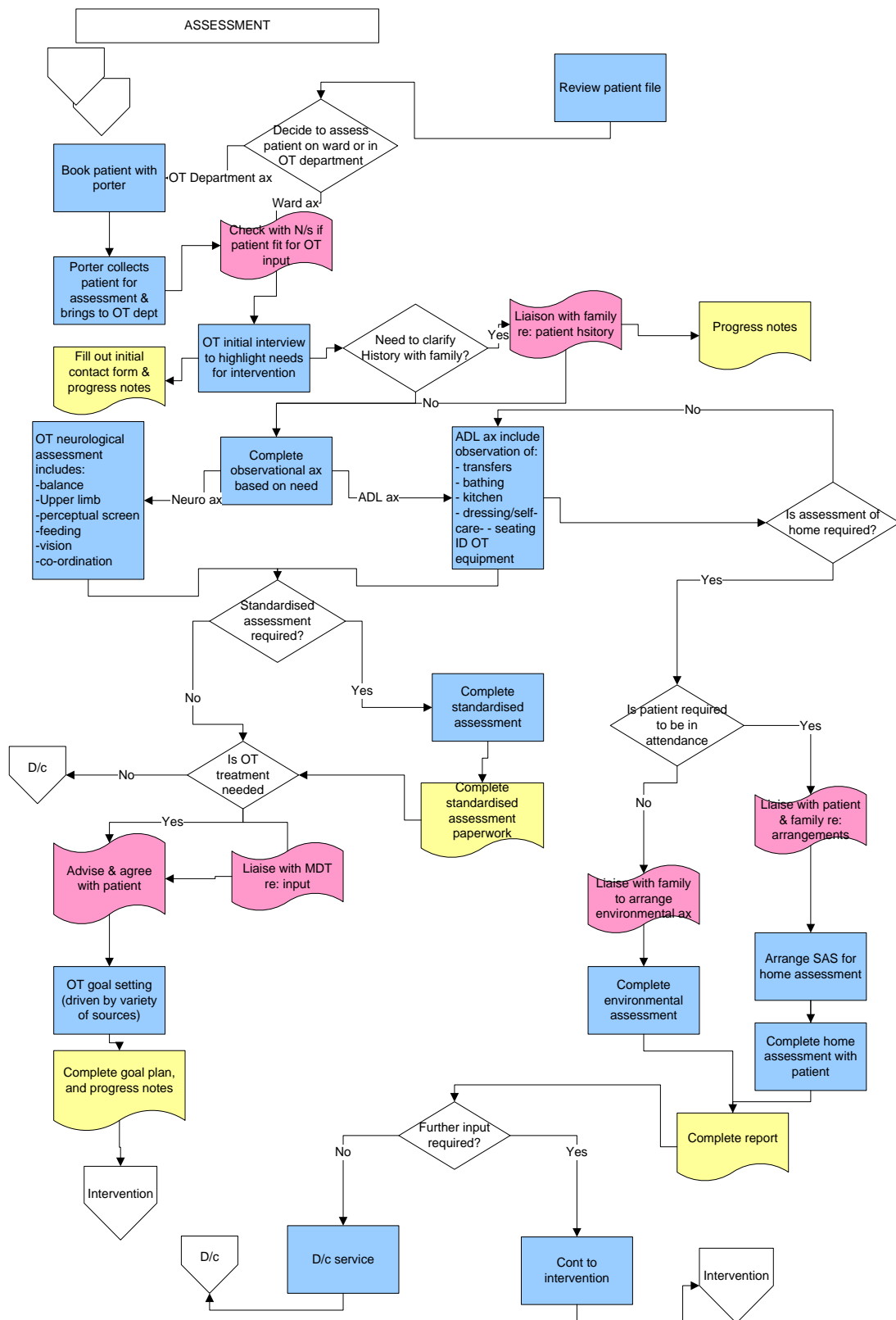
Factors	Colour Codes
Process	Blue
Service Standards/ criteria for service	lilac
Documentation	yellow
Communication	pink
Responsibility	green
Times	orange

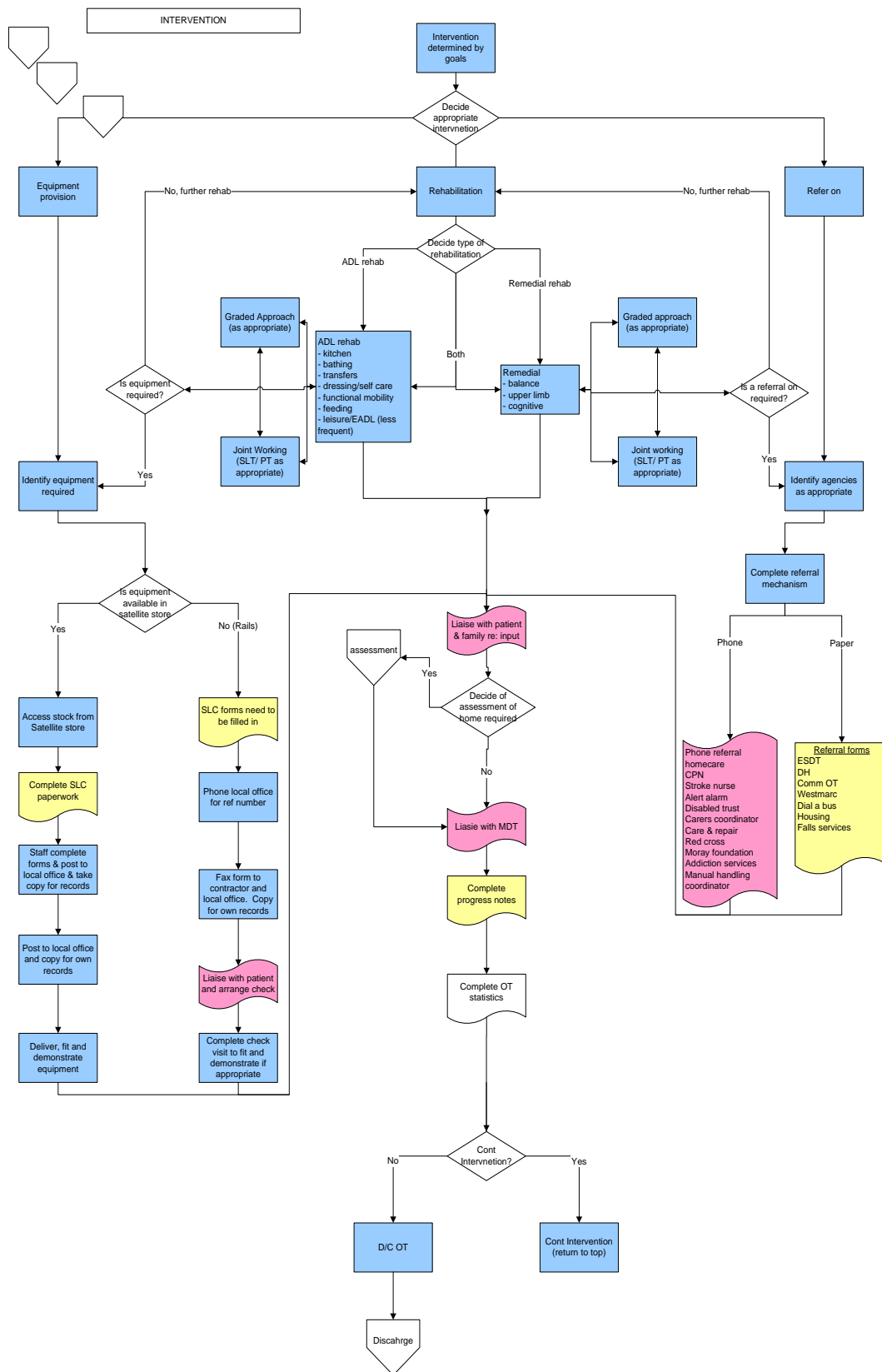
Thank you for your contribution

VISIO Map Examples-Acute In-patient Hospital/ Primary Care ESDT & Local
Authority Occupational Therapy Services

Figure 1 - Inpatient Hospital Map







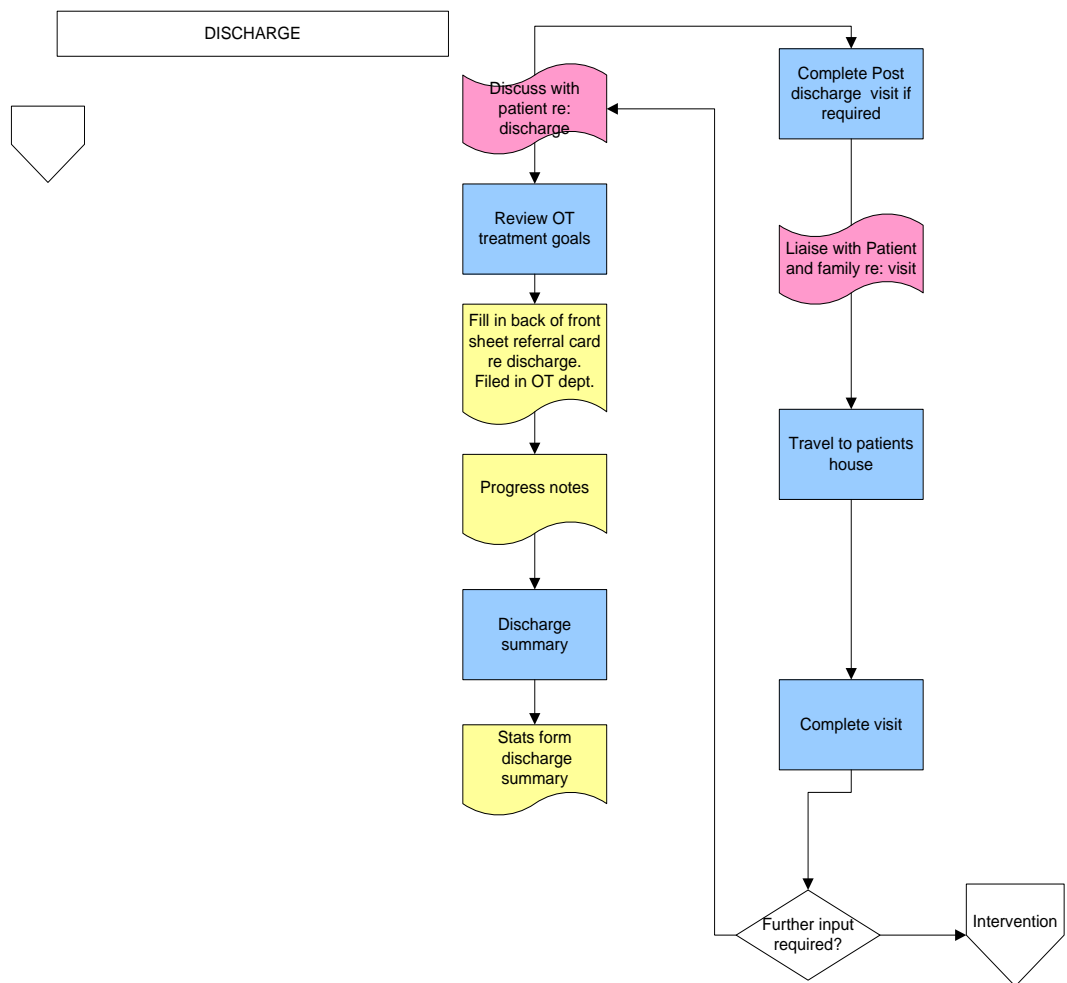
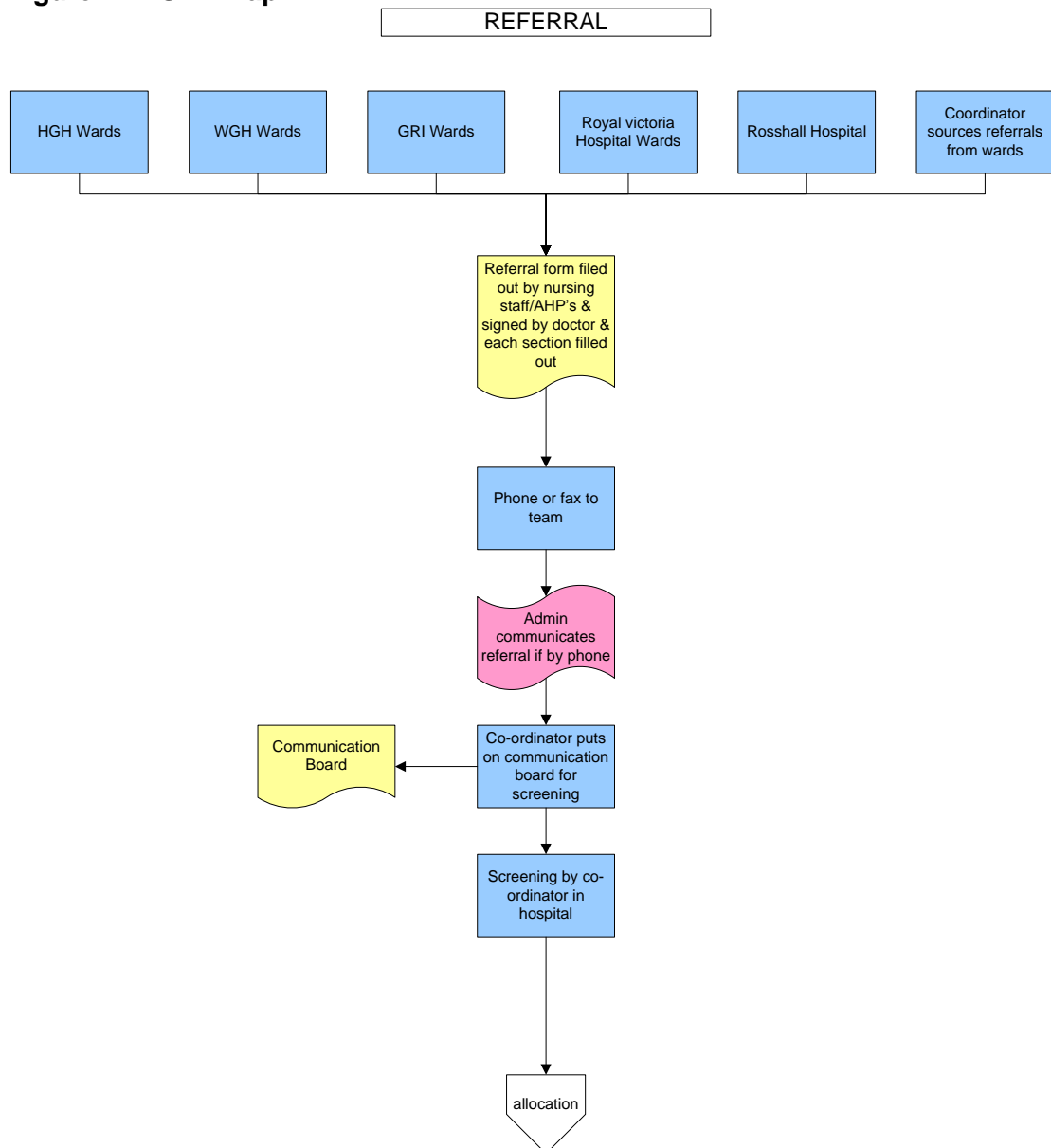
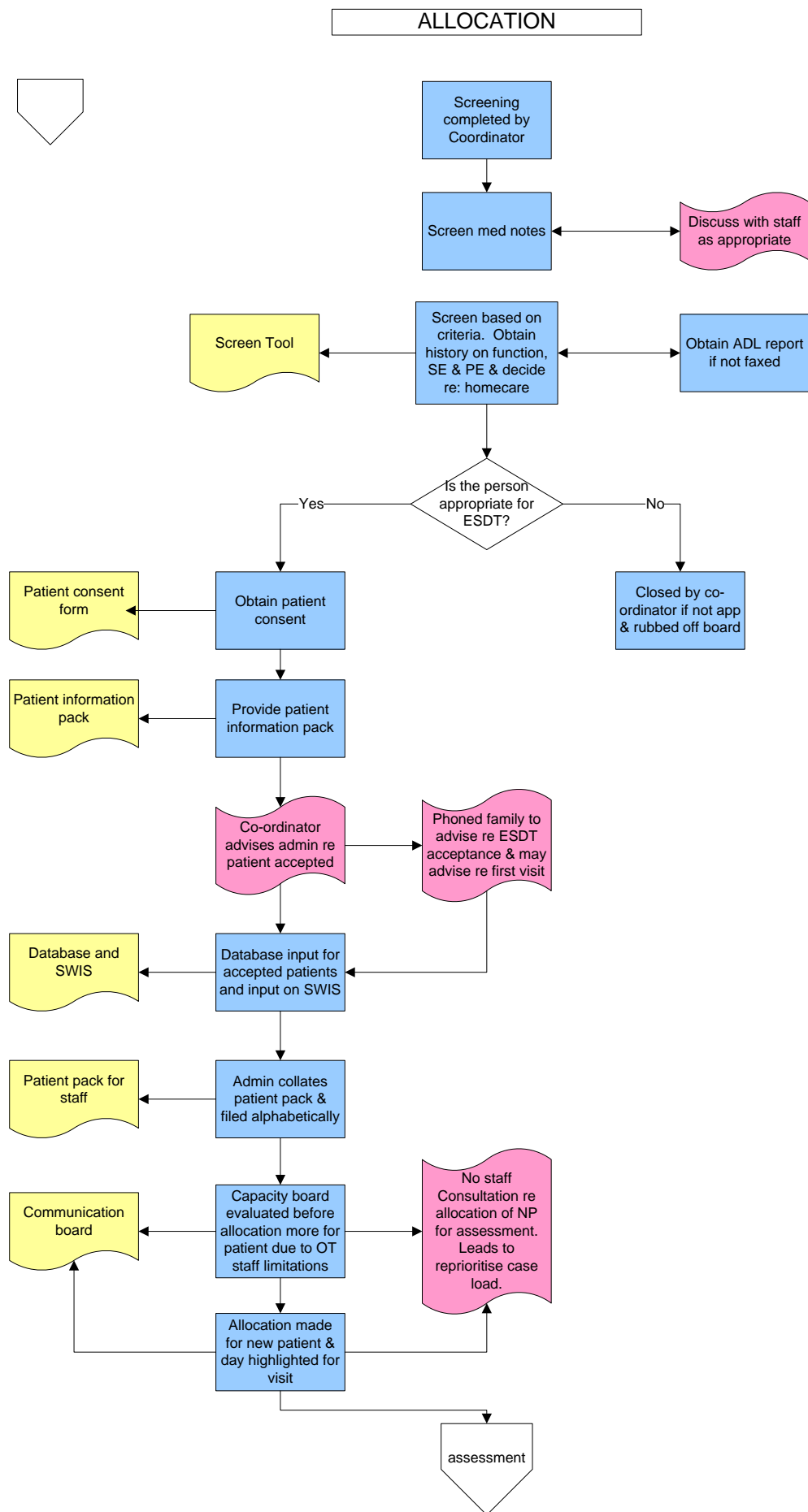
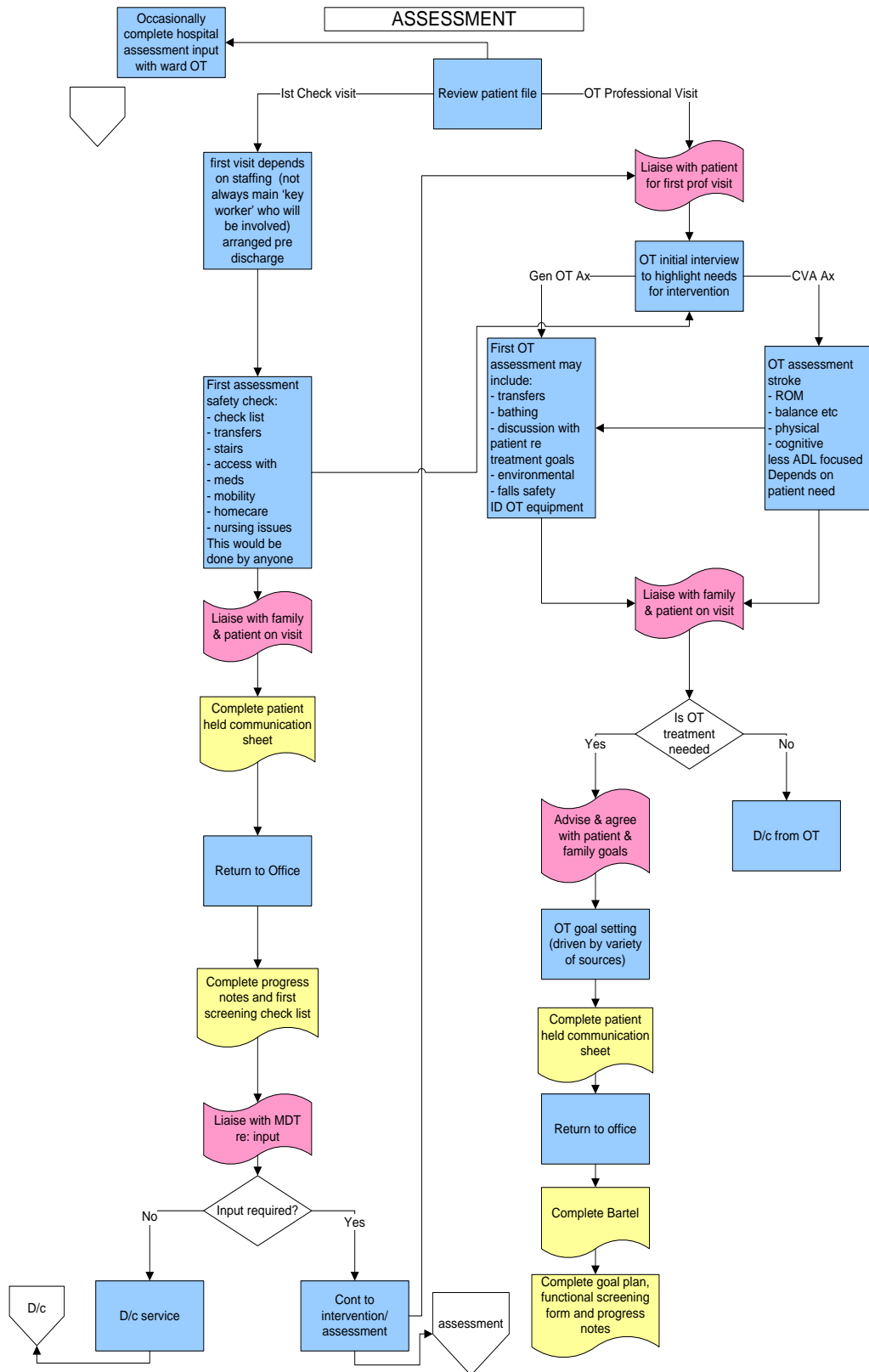
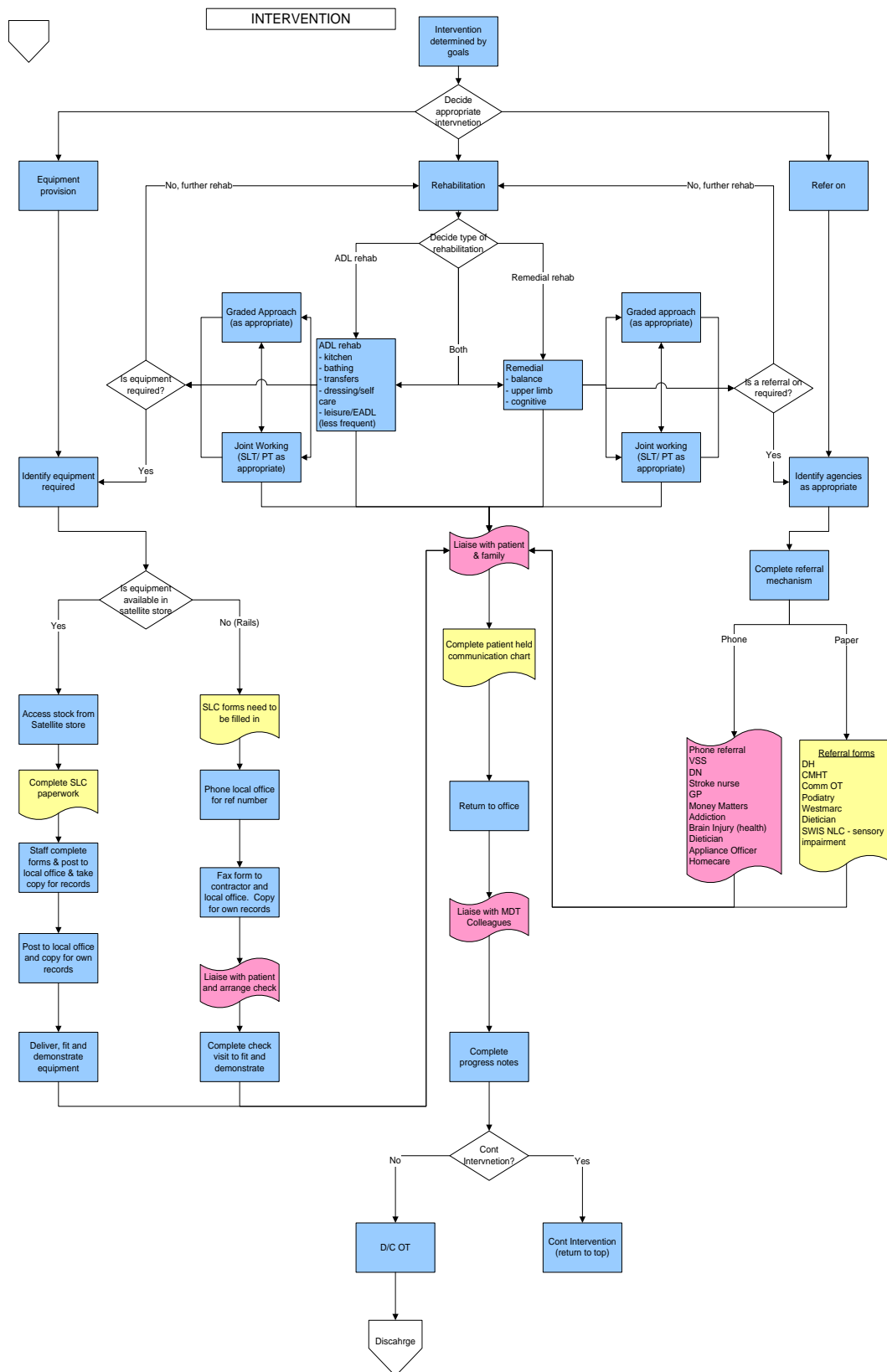


Figure 2 - ESDT Map









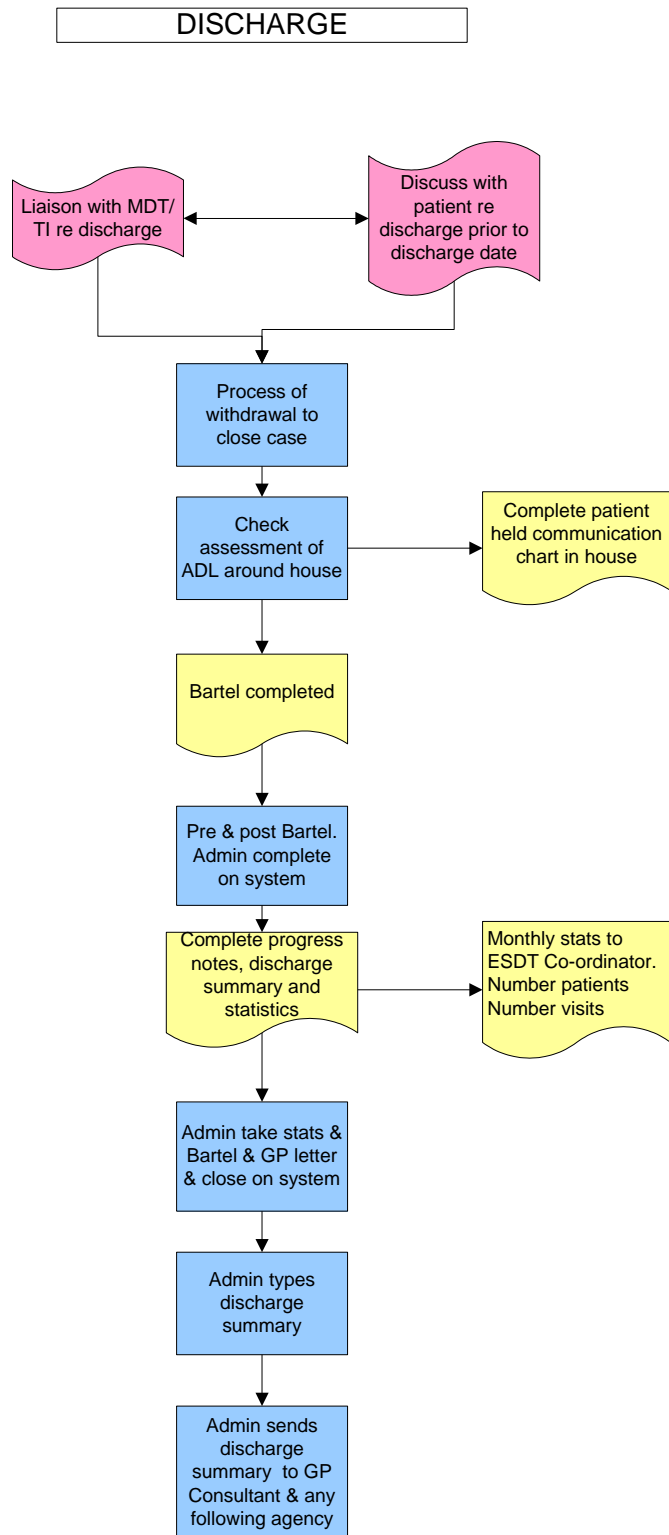
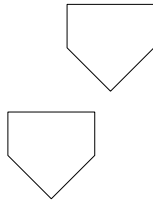
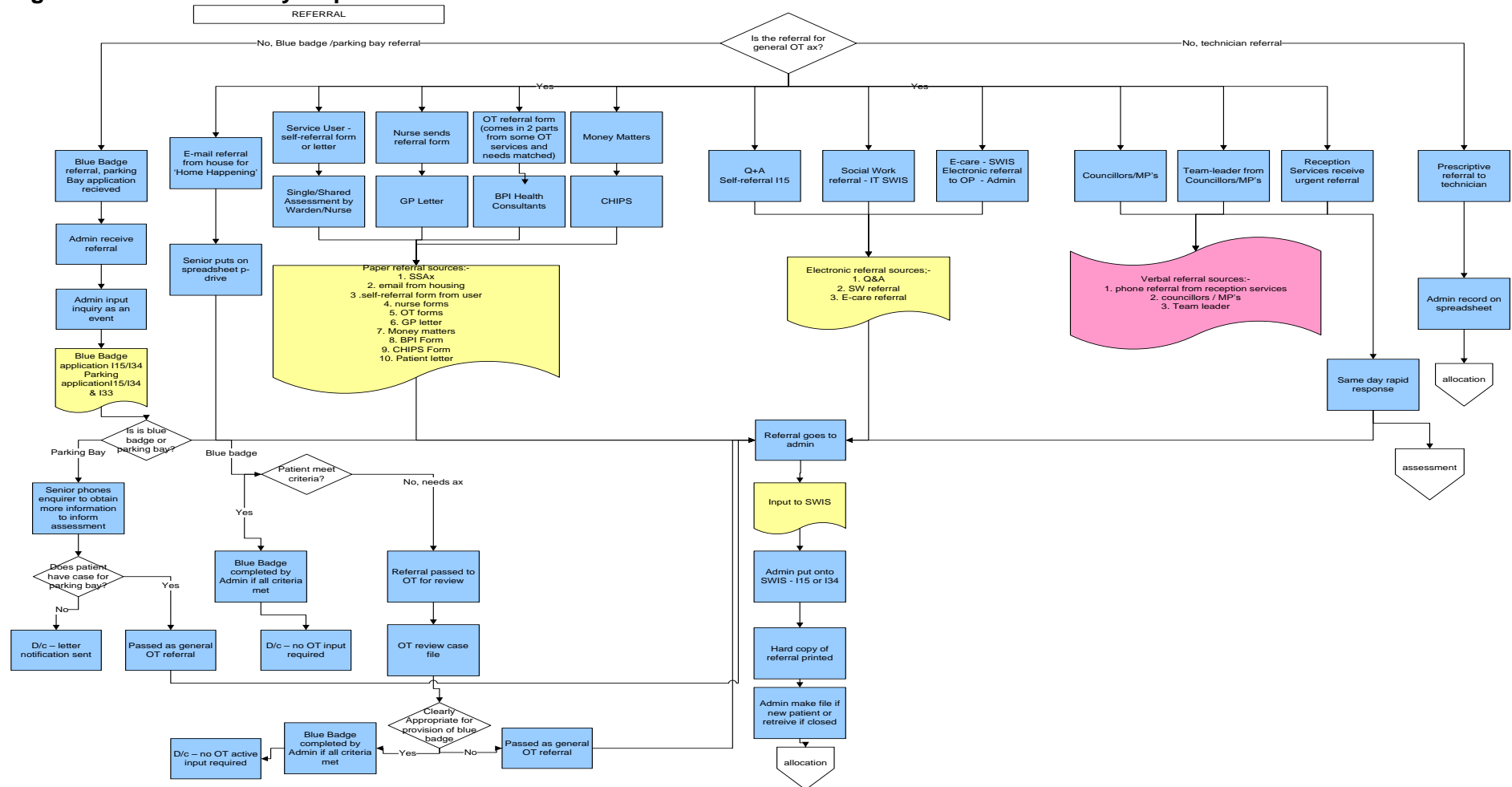
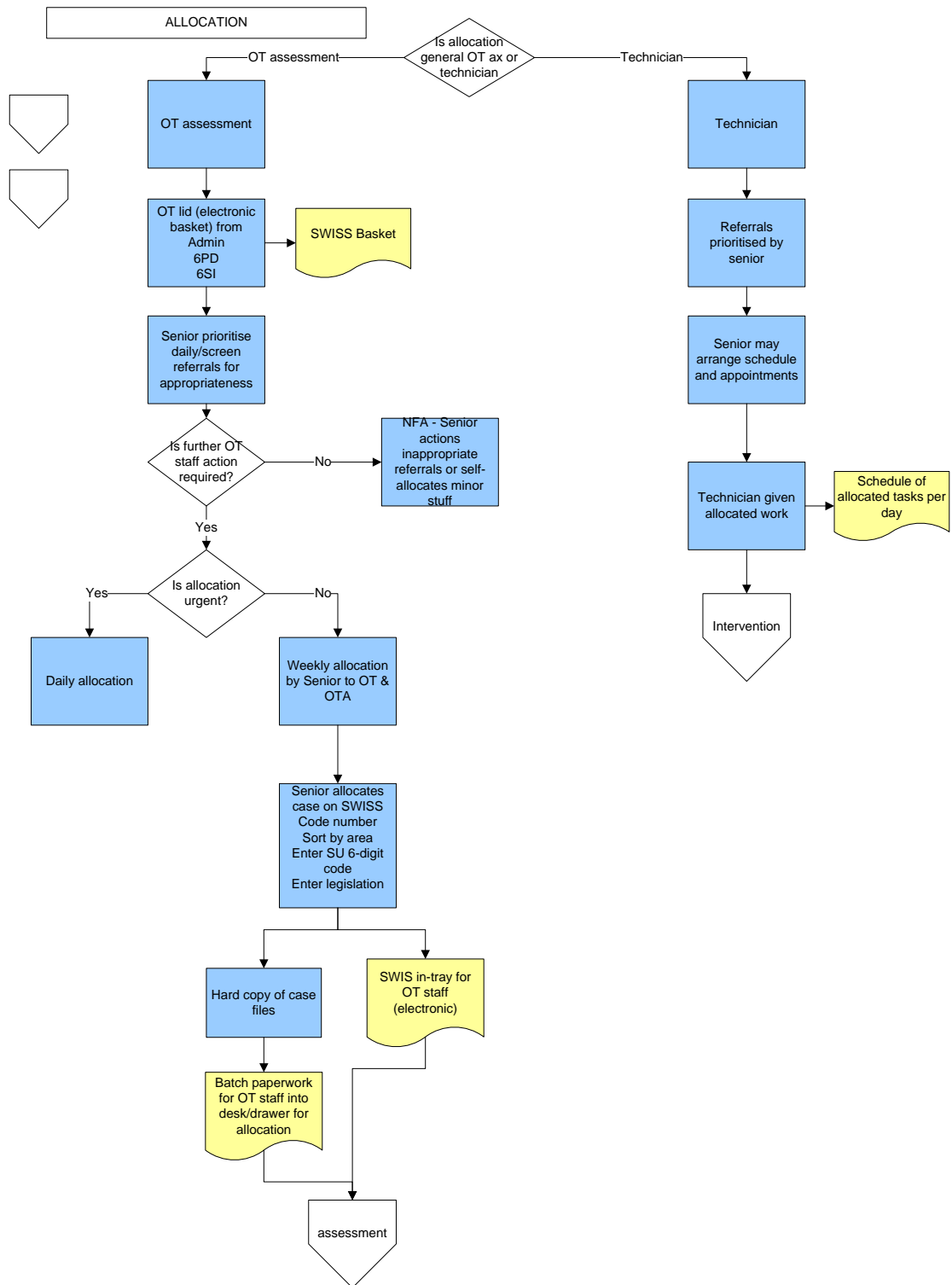
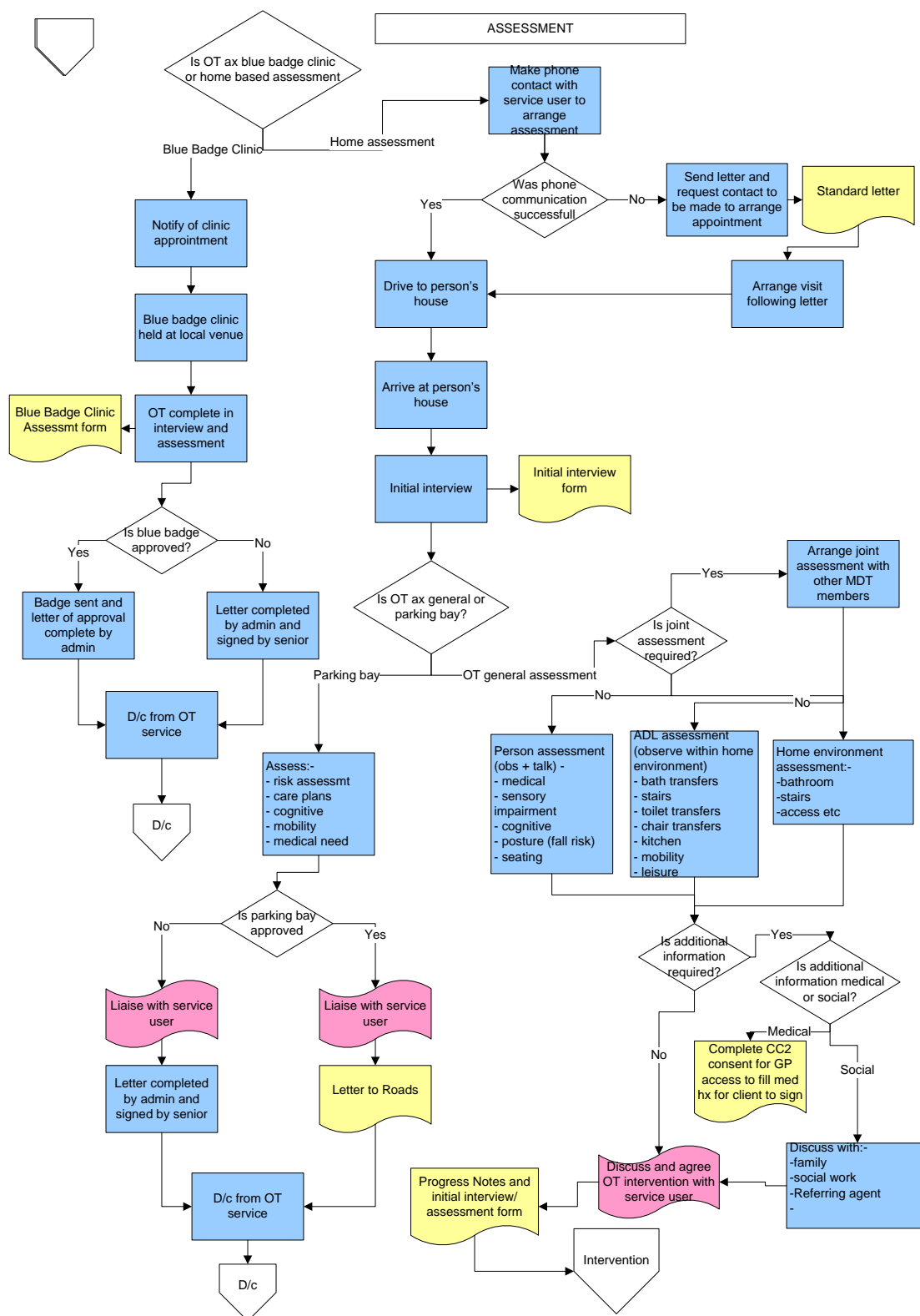
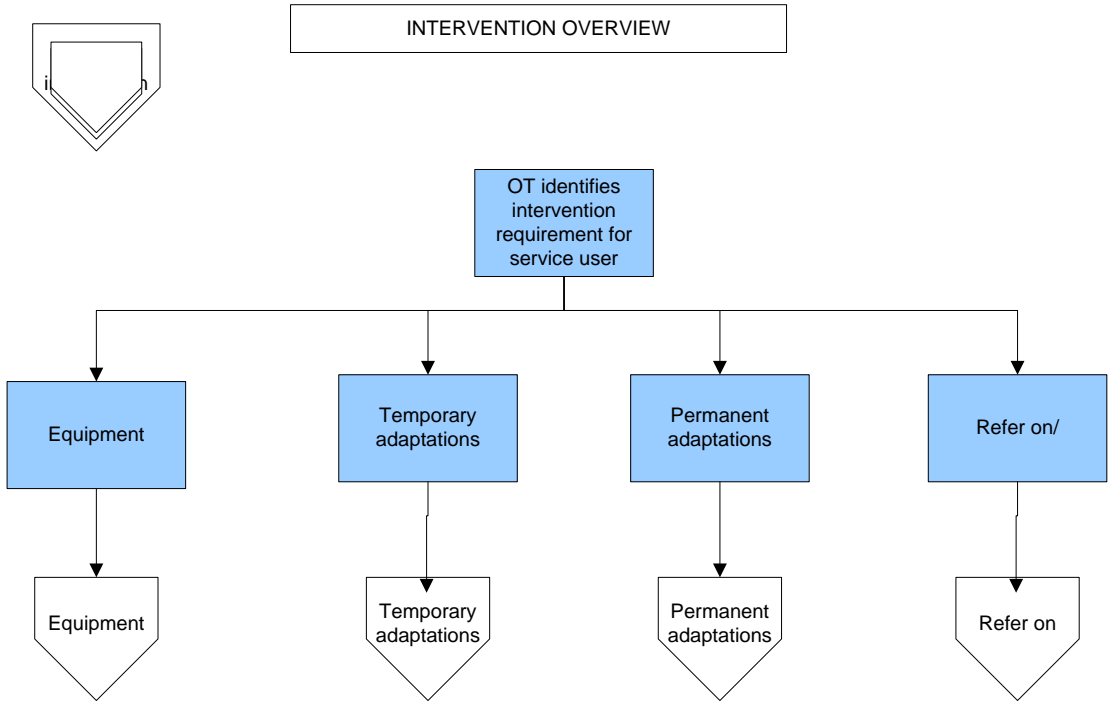


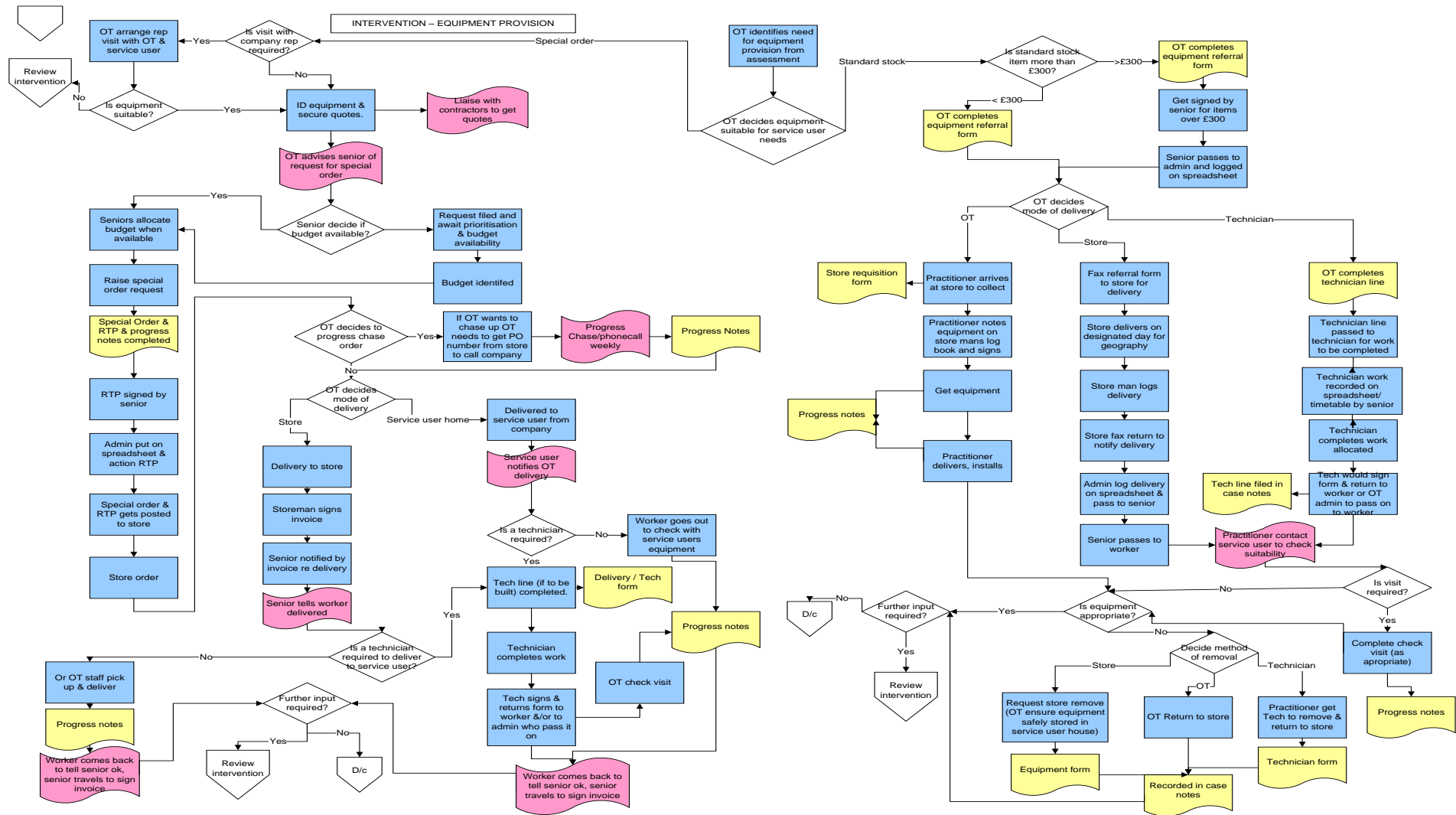
Figure 3 - Local Authority Map

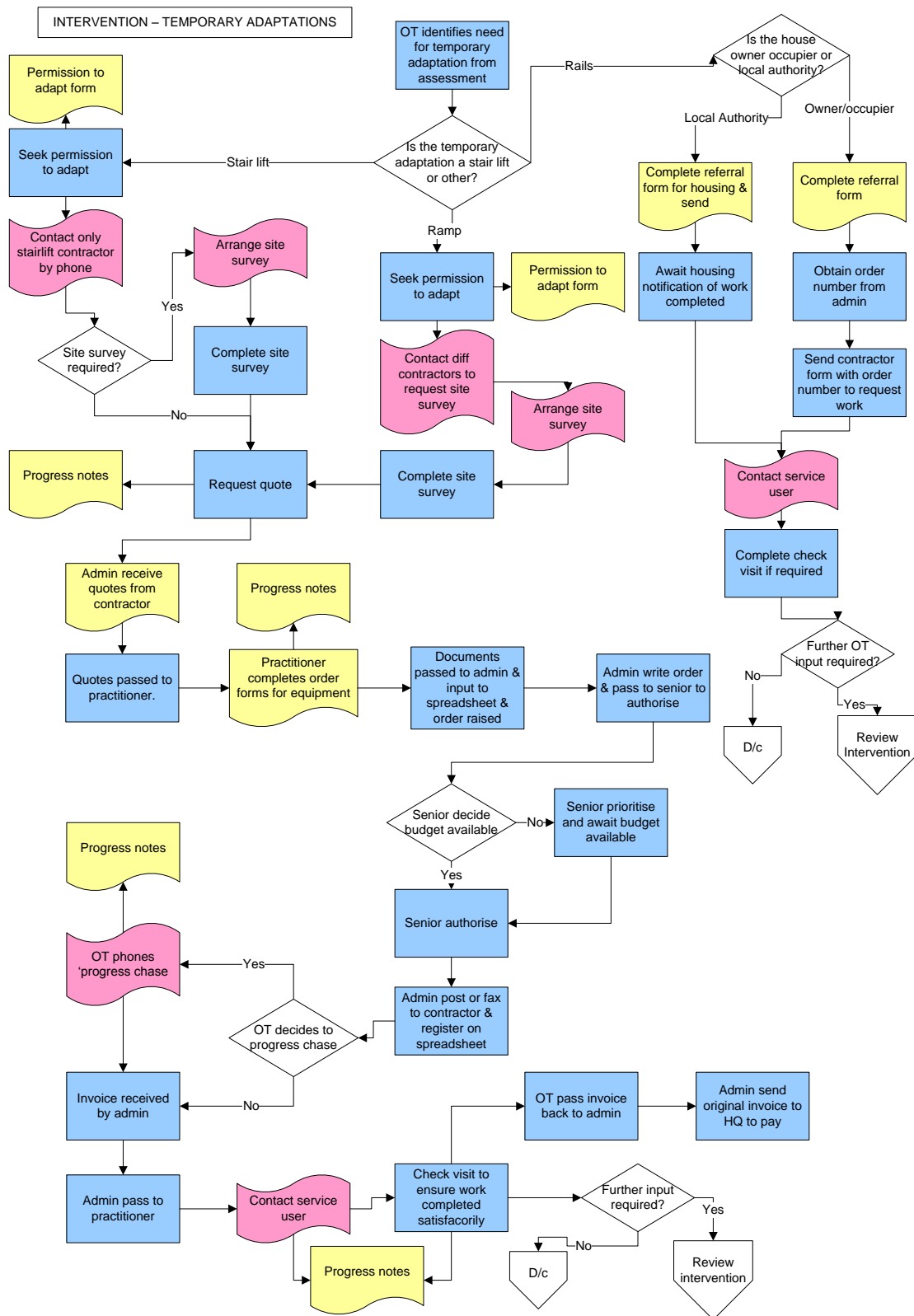


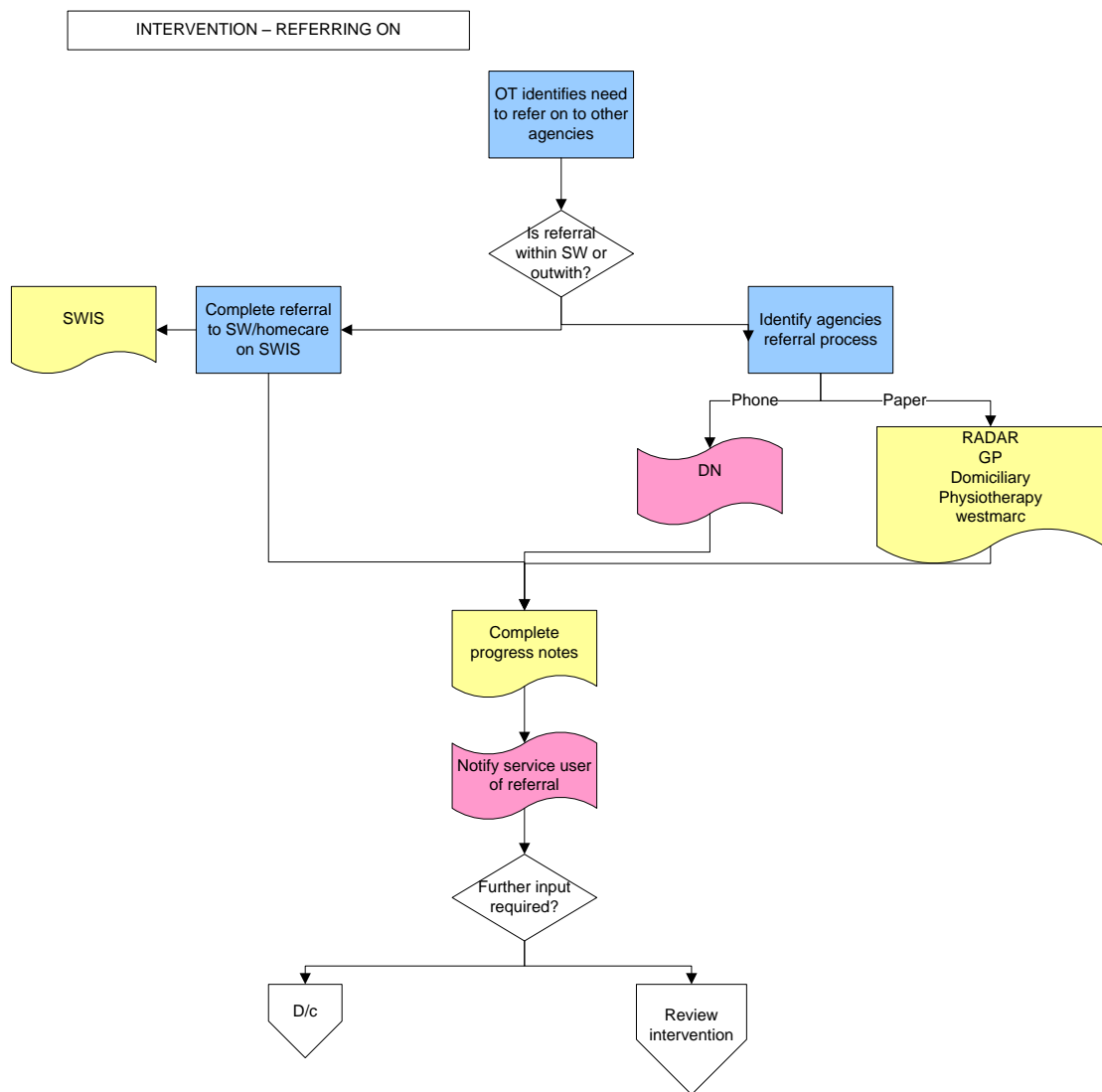




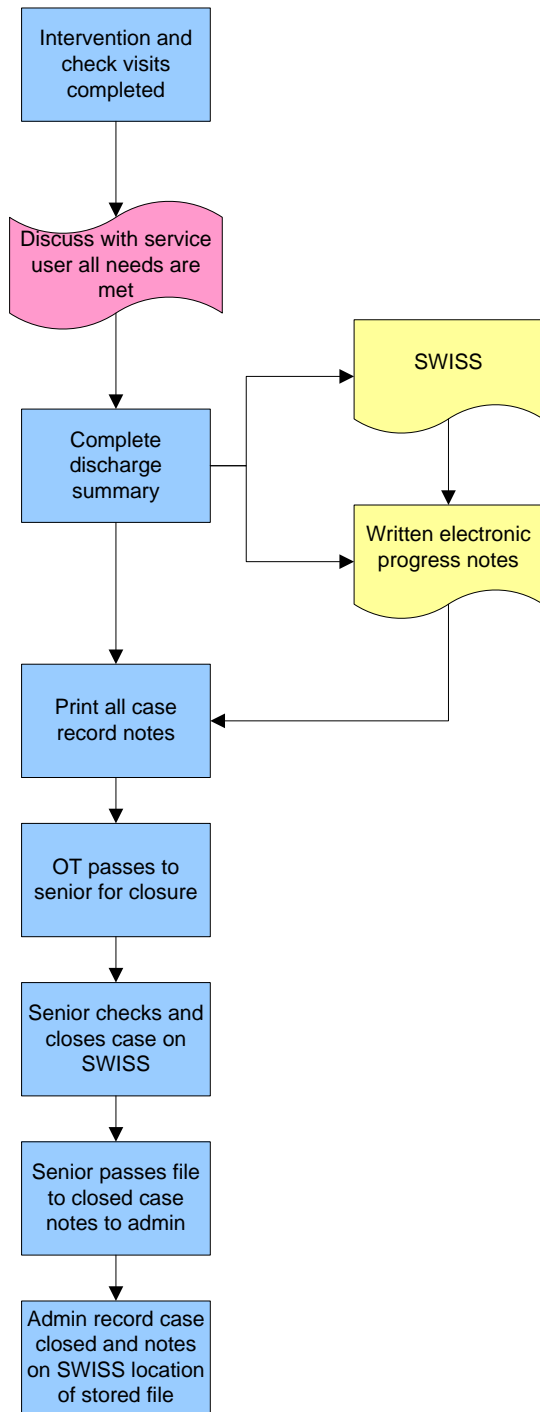
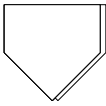


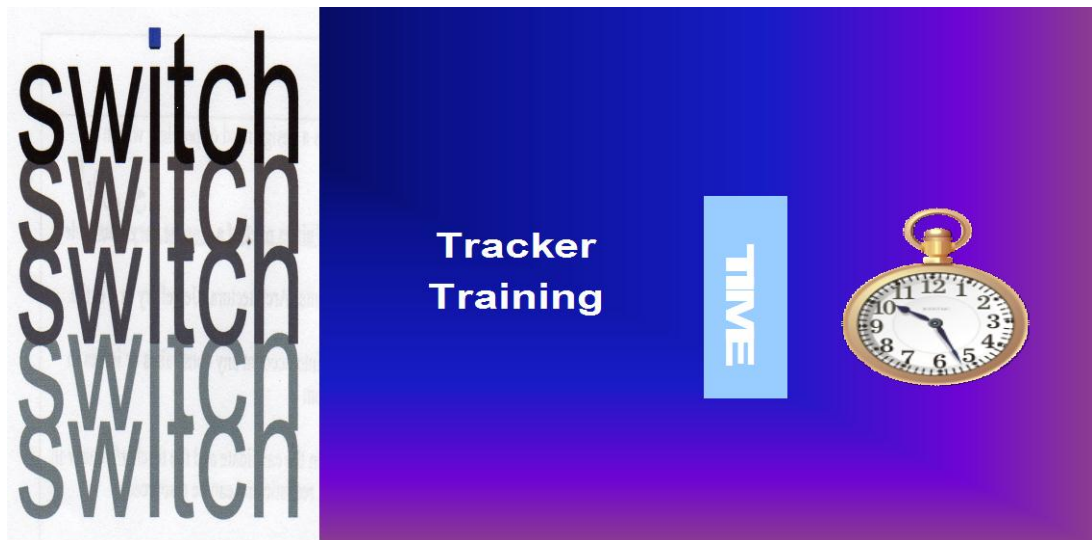






DISCHARGE





**NHS Lanarkshire and
South Lanarkshire Council
Occupational Therapy Service
Redesign**

**Occupational Therapy Tracking
Research Assistant Training Manual**

May 2007

**NHS Lanarkshire and South Lanarkshire Council
Occupational Therapy Service Redesign**

Occupational Therapy Service Tracking: Data Gathering Tool

General Rules

The tracking data gathering tool has been designed to investigate the “task time” associated with the “direct” and “non direct” nature of occupational therapy services to patients/service users, within Acute, Primary Care and Local Authority settings.

The tool’s structure reflects the system constructs common to all occupational therapy services. The system construct categories are:-

- Documentation
- Communication
- Assessment
- Intervention
- Travel” and
- Meetings / Consultation/CPD

These categories are subdivided into a further 6 subsets that provide the framework for data collection and analysis. They are:-

- Classification –defines the task
- Method –defines how the task is being undertaken
- Purpose- defines the intent
- Task time- quantifies the task time associated with the specific task under observation
- Repetition status- defines the number of times the same specific task has been undertaken for exactly the same purpose.
- Outcome- defines the result of the specific task under observation

These subsets have a defined range of fields for selection through the facility of a drop down list.

General rules.

Classification Only **1** “classification” field can be selected during an observation of a specific task listed within all the system construct categories. A classification field must be selected from all the construct categories that best reflects the O.T task being observed.

Method A multiple number of fields within the method subsets of “Documentation”, “Communication”, “Assessment”, and “Intervention” can be selected to reflect the actual activity undertaken to complete a task. It is imperative that the subsets selected are observed and not assumed. Only one field within the method subsets in “Travel” and “Meetings/Consultation/CPD” can be selected

Purpose	Multiple fields can be selected within the "Purpose" subset within all system construct category fields. The "Communication" subset differs slightly in that it requires the research assistant to establish whether the "purpose" is related to an original communication action or whether it is a subsequent "progress chasing" communication action. Original and progress chasing actions cannot be selected simultaneously.
Task time	The task time observed for each episode characterised by the individual classification fields should be recorded accurately.
Repetition status.	Each classification field requires a repetition status. Only 1 repetition status field can be selected. If the task under observation, (denoted by a field) is the first attempt for that occupational therapy episode, then "Original" should be selected; but if the same task under observation has been undertaken before for the same purpose to the same source, then the appropriate "progress chasing" repetition status field should be selected. In most instances the repetition status will require to be confirmed by the O.T. personnel under observation.
Outcome	Only 1 outcome field can be selected in all the subsets, with the exception of documentation which can have multiple field selected
More rules	
Communication	The fields within the communication subset should only be selected when no other field within the other subsets of "Documentation", "Assessment", "Intervention" or "Meetings/Consultation/CPD, can reflect the O.T activity under observation. The activity of "communicating" within the majority of these other categories will be assumed e.g. Document – referral form completion requires communication in some format for the form to be completed.
Assessment	The "Assessment" subset is sectioned into "verbal discussion/interview" and "observation". The distinction is made to reflect the differences in assessment modes i.e the former results in "reported" or "assumed" results, whilst the latter provides "assessed" results. Most occupational therapy assessments will have a combination. The "Assessment" subset is also sectioned to reflect the occupational therapy practice base where the assessment is undertaken Logging the relevant field data in the subset that reflects the assessment <i>mode</i> and <i>practice base</i> is <i>essential</i> . <u>Do not</u> be tempted to log data in the incorrect field for ease!

Other General Guidelines

Seek clarification Although the aim of the study is to be as unobtrusive as possible, it is an unavoidable fact that research assistants will require to seek clarification/confirmation, especially in relation to “Documentation”, “Task Purpose” “Repetition Status” and “Outcome”. Whenever possible, use “closed” questions when confirming/clarifying a point in efforts to avoid unnecessary dialogue/debate. This will require the research assistant to have formulated a judgement about the purpose of the task being observed and relaying that judgement for confirmation

Complete all fields All fields within the data gathering tool must be completed – including the fields at the top of each page which refers to

- Research assistant identifier,
- site location code,
- occupational therapy personnel code and
- date

Documentation - Operational Definitions

Classifications

- **Referral form** – paper or I.T. document which registers a request for service (either into the O.T. service being tracked or a request for service from the O.T service being tracked to another service; including “parallel process” services.
- **Screening form** – paper or I.T. document which documents a standard approach to determine the patient’s /service user’s eligibility for service
- **Initial interview form** – paper or I.T. document which documents the initiation of an occupational therapy assessment through verbal interaction
- **General assessment form(s)** – non standardised paper or I.T. document which records the results/findings of an occupational therapy assessment – verbal or observational
- **Standardised assessment form(s)**.- Standardised paper or I.T document which records the results/findings of an a standardised occupational therapy assessment approach.-verbal or observational
- **Report form(s)** – paper or I.T. document which provides a summarised account of the primary patient/service user assessment results, subsequent occupational therapy intervention and outcomes.
- **Prioritisation form**- paper or I.T document that standardises the approach to prioritising access to occupational therapy services and /or resources
- **Progress notes**- paper or I.T systematic record of occupational therapy inputs specific to an individual patient/service user.
- **Statistical form(s)** – paper or I.T. document that reflects occupational therapy service demand and/or occupational therapy service activity.

Purpose

- **Document referral** – registering referral to occupational therapy service /team
- **Determine eligibility** – accept /refuse referral against specific standard service criteria
- **Determine care coordinator** – identification of key worker to coordinate the service input to patient/service user

- **Documentation of patient history**- record of patient/service user's relevant medical and social history; including any history associated with previous health and social care service intervention
- **Record of reported patient/service user need** – patient service user account of need through verbal discussion / interview with occupational therapy staff. Absence of O.T staff observation of patient/service user undertaking activity to reflect actual need.
- **Record of assessed patient/service user need** - assessment of service user need based on the findings/results of an occupational therapy assessment that involved active observation of patient/service user undertaking the task related to the assessment of need.
- **Record of case formulation /goal setting** – occupational therapy objectives for service intervention specific to the identified needs/aspirations of a specific patient/service user.
- **Application for resources** - requisition for resources based on identified need (assessed or reported)
- **Record of service intervention (direct)** – documentation of occupational therapy service inputs/activities which involved the direct involvement of the patient/service user. This includes telephone conversations where the communication was directly with the patient/service user.
- **Record of service intervention (indirect)**- documentation of occupational therapy service inputs/activities which does not involve the patient/service user directly; but is undertaken in part fulfilment of the occupational therapy intervention on a specific patient/service user's behalf.
- **Closing summary/Record of intervention completion** - summarised account of occupational therapy intervention and indication of intent to close case or confirmation of case closure.
- **Statistical Return** – quantification of service demand to occupational therapy service (referrals) and/or occupational therapy activity.
- **Refer to other services** – transferring part or whole of service responsibility to meet an identified need to another service.

Outcome

- **Filed in service documentation** - documents are filed in occupational therapy service department filing system
- **Filed in MDT files** – occupational therapy documents are filed in medical records
- Filed in Social Work files – occupational therapy documents are filed in social work records.
- **Sent to other service (parallel process)** – documents sent to other services to initiate an action/activity from that service which the occupational therapy service itself is reliant on, to undertake the next stage(s) of the occupational therapy intervention. e.g porter request, to transport patient from ward to O.T department. Technician request to install fit equipment before equipment trial can be undertaken.
- **Sent to other service – (referral)** – Request sent to other service on behalf of service user for service intervention.
- **Inform O.T./Service specific service statistic.** Occupational therapy statistics collated that remains within the auspices of the occupational therapy department

- **Inform management information statistics** – Occupational therapy service statistics collated that is utilised to inform the extended organisational management information
- **Current workload documentation** – paper or I.T. documentation that is current and ongoing

Working Examples

1. Documentation: Referral Form

1.1. Classification	Operational definition	1.2. Purpose	Outcome
Referral form	Referral to O.T. service being tracked	Document referral Determine eligibility for service Documentation of patient history Record of reported patient/service user need	Filed in service documentation
	Referral to another service, including other O.T services	Referral to other services	Sent to other service (parallel process) Sent to other service (Referral)

2. Documentation: Screening Form

Classification	Operational definition	Purpose	Outcome
1.3. Screening form	Form which documents a standard approach to determine the patient's /service user's eligibility for service	Determine eligibility for service (e.g. O.T. Blue Badge, parking bay) Determine priority for service intervention Determine case coordinator	Filed in documentation Sent to other service (referral) e.g. Roads and Transportation (parking bay) Admin –Blue Badge.

3. Documentation: Initial Interview Form(s)

Classification	Operational definition	Purpose	Outcome
1.3. Initial interview form	Form documents the initiation of an occupational therapy assessment through verbal interaction	Determine eligibility for service Documentation of patient history Record patient/service user's reported need Record of service intervention	Filed in documentation Filed in MDT files Filed in Social Work files.

4. Documentation: General Assessment Form(s)

Classification	Operational definition	Purpose	Outcome
General Assessment form(s)	non standardised document which records the results/findings of an occupational therapy assessment – verbal or observational	Record of patient/service user's assessed need* Record of patient/service user's reported need* Case formulation/ goal setting Record of service intervention (direct) Record of service intervention (indirect)	Filed in documentation Filed in MDT files Filed in Social Work files.

5. Documentation: Standardised Assessment Form(s)

Classification	Operational definition	Purpose	Outcome
Standardised assessment form(s)	Document which records the results/findings of an a standardised occupational therapy assessment approach.- verbal or observational	Record of patient/ service user's assessed need Case formulation/ goal setting Record of service Intervention(direct)	Filed in documentation Filed in MDT files Filed in Social Work files. Inform O.T service specific statistics Inform management information

6. Documentation: Report Form(s)

Classification	Operational definition	Purpose	Outcome
Report form(s)	Summarised account of the primary patient/ service user assessment subsequent occupational therapy intervention and outcomes.	Record of patient/service user's reported Record of patient/service user's assessed need Record of service intervention (direct) Record of service intervention (indirect) Application for resources Closing summary/record of intervention completion.	Filed in documentation Filed in MDT files Filed in Social Work files.

7. Documentation: Prioritisation Form(s)

Classification	Operational definition	Purpose	Outcome
Prioritisation form(s)	Document that standardises the approach to prioritising access to occupational therapy services and /or resources.	Prioritisation for intervention	Filed in documentation

8. Documentation: Progress Notes

Classification	Operational definition	Purpose	Outcome
1.4 Progress Notes	Record of occupational therapy inputs specific to an individual patient/service user.	Record of patient/service user history Record of patient/service user reported need Record of patient/service user assessed need	Filed in documentation Filed in MDT files Filed in Social Work files

		Record of case formulation/goal setting Record of service intervention (direct) Record of service intervention (indirect) Closing summary/record of intervention completion	
--	--	--	--

Communication – Operational Definitions

Classifications

- **Patient/service user** –Service recipient who receives occupational therapy. The term “patient” is synonymous with NHS service; whilst the term “service user” is more frequently utilised with South Lanarkshire Council services
- **Carer (informal)** – person who supports patient/service user in the community setting without financial remuneration.
- **Professional liaison (O.T Acute)** – Occupational therapy personnel employed within NHS Acute services
- **Professional liaison (O.T. Primary Care)** - Occupational therapy personnel employed within NHS Primary Care.
- **Professional liaison (O.T Local Authority)**-Occupational therapy personnel employed within South Lanarkshire Council Physical Disability and Sensory Impairment Services
- **Other professional liaison (Acute)**– All personnel employed within NHS Acute services
- **Other professional liaison (Primary Care)**– All personnel employed within NHS Primary Care services
- **Other professional liaison (Local Authority)**– All personnel employed within South Lanarkshire Council
- **Other professional liaison (Vol Org)**– All personnel employed within the extended voluntary organisations
- **Other professional liaison (Private)** – All personnel employed within private organisations.

Purpose

- **Obtaining information** – Communication to illicit information in efforts to progress the service objectives in relation to, or on behalf of a specific patient/service user
- **Relaying information**-Communication to impart information in efforts to progress the service objectives in relation to, or on behalf of a specific patient/service user- other than the communication action of “referring on”
- **Confirming information** – Communication actions to verify existing information from either the original source of the information or from alternative source(s)
- **Referring on** – Communication action that requests intervention of other services on behalf of a specific patient/service user.
- **Progress chasing equipment and adaptations assessment (SW)**-Communication action to South Lanarkshire Council occupational therapy personnel involved in the care of a specific patient/service user, to establish

that service's status/progress in respect to providing the requested assessment for equipment and/or adaptations. The request for service need not have originated from the service progress chasing the request.

- **Progress chasing equipment provision (SW)** Communication action to South Lanarkshire Council occupational therapy personnel involved in the care of a specific patient/service user, to establish that service's status/progress in respect to providing the equipment, either directly requested (⁷⁴ prescriptive referral) by the progress chasing employee; or requested from another source.
- **Progress chasing equipment (Supplier)** – Communication action to a commercial equipment supplier to establish the status/progress of that supplier delivering the specified item(s) in line with the order placed on behalf of a specific patient/service user. This should include “temporary adaptations” such as stairlifts.
- **Progress chasing equipment (Store)** Communication action to the statutory equipment store to establish the status/progress of that service delivering, uplifting or fitting the specified item(s) in line with the order placed on behalf of a specific patient/service user
- **Progress chasing adaptations (Housing)** Communication action to social housing landlords, including South Lanarkshire Council, Housing and Technical Resources and local Housing Associations; to establish the status/progress of undertaking/commissioning the adaptations in line with the referral/requisition placed on behalf of a specific patient/service user.
- **Progress chasing adaptations (Contractor)** Communication action to private contractor, commissioned to undertake specified adaptations to a property on behalf of a specific patient/service user; to establish the status/progress of the adaptations works in line with the order.
- **Progress chasing adaptations (Legal)**. Communication action to either South Lanarkshire Council legal services or direct communication action to a solicitor appointed by the patient/service user (or representative); to establish the status/progress of completing and submitting the legal documents relating to the adaptations service.
- **Progress chasing adaptations (Architects)** Communication action to either South Lanarkshire Council architects services or direct communication action to an architect appointed by the patient/service user (or representative); to establish the status/progress of completing and submitting the plans relating to the proposed adaptations.
- **Progress chasing (Medics)** Communication action to obtain information and/or establish the status/progress of an action previously requested from medical colleagues about a specific patient/service user
- **Progress chasing (Nursing)** Communication action to obtain information and/or establish the status/progress of an action previously requested from NHS Acute nursing colleagues about a specific patient/service user
- **Progress chasing (Community nursing)** Communication action to obtain information and/or establish the status/progress of and action previously requested from NHS Primary Care nursing colleagues about a specific patient/service user

⁷⁴ Prescriptive referral – referral made from NHS Lanarkshire occupational therapy services which is honoured by South Lanarkshire Council occupational therapy services without reassessment.

- **Progress chasing (Ambulance)** Communication action to obtain information and/or establish the status of an action previously requested from the ambulance service about a specific patient/service user
- **Progress chasing (Homecare)** Communication action to obtain information and/or establish the status/progress of an action previously requested from South Lanarkshire Council homecare services or independent homecare agency on behalf of a specific patient/service user.
- **Progress chasing (other)** Any communication action to obtain information and/or establish status/progress of an action previously requested from any organisation/service/person not listed above, on behalf of a specific patient/service user. The patient/service user themselves may be the one “progress chased” on information /outstanding action other than that encapsulated within the “progress chase adaptations (Service user)

Outcomes

- **Action complete** – This outcome category should be selected if the “progress chasing” activity obtains all the previously requested information or if there is confirmation that the outstanding previously requested “action” from the service is complete. If *additional* information or actions are requested at the “progress chasing” stage by the O.T staff member, then the outcome category selected should be “Action complete”, as the additional information/action requested is a new request.
- **Action partially complete-** This outcome category should be selected when only part of the information/action previously requested is provided or completed.
- **Action incomplete-** This outcome category should be selected if none of the information previously requested is provided **or** if the “action” requested is outstanding –even if a future date for completion is given.

Working Examples

1. Communication: Patient/Service User

Classification	Operational definition	Purpose	Outcome
Patient/Service User	Service recipient who receives occupational therapy	Obtain information Relay information Confirm information Progress chasing adaptations(service user) Progress chasing (other)	Action complete Action Partially complete Action incomplete

2. Communication: Carer (informal)

Classification	Operational definition	Purpose	Outcome
Carer (informal)	person who supports patient/service user in the community setting without financial remuneration	Obtain information Relay information Confirm information Progress chasing adaptations(service user) Progress chasing (other)	Action complete Action Partially complete Action incomplete

3. Communication: Professional liaison – O.T (Acute)

Classification	Operational definition	Purpose	Outcome
Professional liaison – O.T (Acute)	Occupational therapy personnel employed within NHS Acute services	Obtain information Relay information Confirm information Referring on Progress chasing (other)	Action complete Action Partially complete Action incomplete

3. Communication: Professional liaison – O.T. (Primary Care)

Classification	Operational definition	Purpose	Outcome
Professional liaison – O.T. (Primary Care)	Occupational therapy personnel employed within NHS Primary Care.	Obtain information Relay information Confirm information Referring on Progress chasing (other)	Action complete Action Partially complete Action incomplete

4. Communication: Professional liaison – O.T. (Local Authority)

Classification	Operational definition	Purpose	Outcome
Professional liaison – O.T. (Local Authority)	Occupational therapy personnel employed within South Lanarkshire Council Physical Disability and Sensory Impairment Services	Obtain information Relay information Confirm information Referring on Progress chasing – equipment and adaptations assessment (sw) Progress chasing – equipment provision (SW) Progress chasing (other)	Action complete Action Partially complete Action incomplete

5. Communication: Other professional liaison –Health Acute

Classification	Operational definition	Purpose	Outcome
Other professional liaison –Health Acute	All personnel employed within NHS Acute services	Obtain information Relay information Confirm information Referring on Progress chasing (medics) Progress chasing (nursing) Progress chasing (ambulance) Progress chasing (other)	Action complete Action Partially complete Action incomplete

6. Communication: Other professional liaison – Primary Care

Classification	Operational definition	Purpose	Outcome
Other professional liaison – Primary Care	All personnel employed within NHS Primary Care services	Obtain information Relay information Confirm information Referring on Progress chasing (medics) Progress chasing (community nursing) Progress chasing (ambulance) Progress chasing (other)	Action complete Action Partially complete Action incomplete

7. Communication: Other professional liaison – Local Authority

Classification	Operational definition	Purpose	Outcome
Other professional liaison – Local Authority	All personnel employed within South Lanarkshire Council	Obtain information Relay information Confirm information Referring on Progress chasing-equipment(store) Progress chasing-adaptations (housing) Progress chasing-adaptations (legal) Progress chasing adaptations (architects) Progress chasing (homecare) Progress chasing (other)	Action complete Action Partially complete Action incomplete

8. Communication: Other professional liaison –voluntary organisations

Classification	Operational definition	Purpose	Outcome
Other professional liaison- voluntary organisations	All personnel employed within the extended voluntary organisations	Obtain information Relay information Confirm information Referring on Progress chasing (other)	Action complete Action Partially complete Action incomplete

10. Communication: Other professional liaison - private

Classification	Operational definition	Purpose	Outcome
Other professional liaison	All personnel employed within private organisations.	Obtain information Relay information Confirm information Progress chasing (homecare) Progress chasing (architects) Progress chasing (legal) Referring on Progress chasing (other)	Action complete Action Partially complete Action incomplete

Assessment – Operational definition

Classification

- **Mobility (gait/wheelchair)-** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's functional mobility with or without mobility equipment
- **Stair climbing/descent (internal)** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's functional mobility ascending and/or descending the internal stairs with or without equipment/adaptations
- **Stair climbing/descent (external)** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's functional mobility ascending and/or descending external stairs with or without equipment/adaptations
- **Bath transfers** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in re to transferring in/out of the bath with or without equipment/adaptations. The assessment does not include the actual self care task of bathing
- **Bed transfers** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in re to transferring on/off and manoeuvring on the bed, with or without equipment/adaptations. The assessment does not include the associated self care task of dressing/undressing
- **Chair transfer** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in re to transferring on/off the chair, with or without equipment/adaptations
- **Toilet transfer** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in re to transferring on/off the toilet, with or without equipment/adaptations. The assessment does not include the associated self care tasks of adjusting clothing, cleaning self.
- **Self care** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in self care tasks which include, dressing, washing, bathing, cleaning teeth grooming, shaving, make-up etc

- **Productivity** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in, for example, domestic activities, life roles (parenting grand-parenting) and/or vocational interests etc
- **Leisure** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's abilities/limitations in leisure pursuits
- **Cognitive assessment** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's cognitive functional level and to determine the rehab potential and the impact on activities of daily living
- **Perceptual assessment** Occupational therapy assessment where the primary focus of the assessment is to establish the level and nature of the patient/service user's perceptual deficits and to determine the rehab potential and the impact on activities of daily living
- **Sensory assessment** Occupational therapy assessment where the primary focus of the assessment is to establish the level and nature of the patient/service user's sensory deficits and to determine the rehab potential and the impact on activities of daily living
- **Biomechanical assessment.** Occupational therapy assessment where the primary focus of the assessment is to establish the level and nature of biomechanical dysfunction and determine the rehab potential and the impact on activities of daily living
- **Social Environment** Occupational therapy assessment where the primary focus of the assessment is to establish the patient/service user's existing support network and identify support requirements as is necessary
- **Physical Environment.** Occupational therapy assessment where the primary focus of the assessment is to identify physical barriers to independence and consider potential adaptations to meet the needs of a specific patient/service user
- **Risk –** Occupational therapy risk assessment that measures “risk taking” by patient/service users and carers (informal), in activities of daily living; and determines the requirement to address the identified “risk” through compensatory action/approaches
- **Other –** Any other assessment that occupational therapy service personnel are engaged in within practice settings.

Purpose

- **Determine patient/service user's eligibility for service-** Screening function to determine patient/service user's readiness/appropriateness for occupational therapy service
- **Determine patient/service user's reported functional status –** Occupational therapy assessment conducted via verbal discussion/interview, establishing the *reported* functional level of the patient/service user
- **Determine patient/service user's assessed functional status–** Occupational therapy assessment conducted via verbal discussion/interview and observation, establishing the *assessed* functional level of the patient/service user
- **Determine service intervention objectives.** Assessment result formulated into occupational therapy service objectives for intervention in collaboration with patient/service user

- **Determine suitability of home environment.** Confirmation as to the suitability (or otherwise) of the patient/service user's home environment vis a vis the patient's service user's functional level
- **Determine suitability of other environment.** Confirmation as to the suitability (or otherwise) of the environments the patient/service user requires/wishes to access vis a vis the patient/service user's functional level
- **Determine patient/service user's Support infrastructure.** Quantify the formal and informal support network experienced by the patient/ service user
- **Determine Service user's safe discharge status** (or otherwise) of a patient/service user's physical, social, psychological and environmental readiness for safe discharge
- **Follow-up/review.** Assessment to review impact/outcome of occupational therapy service intervention

Outcome

- **Service referral accepted.** Service assessment determines that patient/service user meets the occupational therapy service criteria for further intervention.
- **Service referral declined –NFA.** Service assessment determines that patient/service user does not meet the occupational therapy service criteria for further intervention. No needs identified and case closed.
- **Service referral declined and referred on.** Service assessment determines that patient/service user does not meet the occupational therapy service criteria for further intervention but patient/service user needs are identified that are referred to another appropriate service
- **Further assessment required.** Further occupational therapy assessment required to determine patient/service user eligibility/readiness for service
- **Discharged home.** Patient/service user discharged home
- **Assessment complete.** Occupational therapy assessment complete

Working Examples

1. Assessment: Verbal discussion/Interview (Health setting)

Classification	Operational definition	Purpose	Outcome
Mobility (gait/wheelchair) Stair climbing/descent (internal) Stair climbing/descent (external) Bath transfer Bed transfer Chair transfer Toilet transfer Self care Productivity Leisure	Assessment to establish the patient/service user's functional abilities/limitations with or without equipment	Determine patient/service user 's eligibility for service. Determine patient/service user's <i>reported</i> functional status. Determine service intervention objectives Quantify patient/service user's formal and informal support network.	Service referral accepted Service referral declined-NFA Service referral declined and referred on. Further assessment required

1.4. Social environment			Discharged home Assessment complete
--------------------------------	--	--	--

2. Assessment: Observation of patient/service user (Health setting)

Classification	Operational definition	Purpose	Outcome
Mobility (gait/wheelchair) Stair climbing/descent (internal) Stair climbing/descent (external) Bath transfer Bed transfer Chair transfer Toilet transfer Self care Productivity Cognitive assessment Perceptual assessment Sensory assessment Biomechanical assessment Risk Other	Assessment to establish the patient/service user's functional abilities/limitations with or without equipment	Determine patient/service user's eligibility for service. Determine patient/service user's functional status. Determine service intervention objectives	Service referral accepted Service referral declined-NFA Service referral declined and forwarded Further assessment required Discharged home Assessment complete

3. Assessment: Verbal discussion (Home environment)

Classification	Operational definition	Purpose	Outcome
Mobility (gait/wheelchair) Stair climbing/descent (internal) Stair climbing/descent (external) Bath transfer Bed transfer Chair transfer Toilet transfer Self care Productivity Leisure	Assessment to establish the patient/service user's functional abilities/limitations with or without equipment	Determine patient/service user 's eligibility for service. Determine patient/service user's <i>reported</i> functional status. Determine patient/service user's formal and informal support network	Service referral accepted Service referral declined-NFA Service referral declined and forwarded

Cognitive assessment Perceptual assessment Sensory assessment Biomechanical assessment Physical environmental assessment Social environmental assessment Risk Other		Determine suitability of home environment Determine service intervention objectives Follow up/review	Further assessment required Discharged home Assessment complete
--	--	--	---

4. Assessment: Observation of service user/patient (Home environment)

Classification	Operational definition	Purpose	Outcome
Mobility (gait/wheelchair) Stair climbing/descent (internal) Stair climbing/descent (external) Bath transfer Bed transfer Chair transfer Toilet transfer Self care Productivity Leisure Cognitive assessment Perceptual assessment Sensory assessment Biomechanical assessment Physical environment assessment Social environment assessment Risk Other	Assessment to establish the patient/service user's functional abilities/limitations with or without equipment	Determine patient/service user's eligibility for service. Determine patient/service user's functional status. Determine service intervention objectives Determine patient/service user's formal and informal support network Determine suitability of home environment Determine safe discharge status Follow- up/review	Service referral accepted Service referral declined-NFA Service referral declined and forwarded Further assessment required Discharged home Assessment complete

5. Assessment: Verbal discussion (other setting)

Classification	Operational definition	Purpose	Outcome
Mobility (gait/wheelchair) Stair climbing/descent (internal) Stair climbing/descent (external) Bath transfer Bed transfer Chair transfer Toilet transfer Self care Productivity Leisure Cognitive assessment Perceptual assessment Sensory assessment Biomechanical assessment Physical environmental assessment Social environment assessment Risk Other	Assessment to establish the patient/service user's functional abilities/limitations with or without equipment	Determine patient/service user 's eligibility for service. Determine patient/service user's reported functional status. Determine service intervention objectives Determine patient/service user's formal and informal support network Determine suitability of other environment Follow- up/review	Service referral accepted Service referral declined-NFA Service referral declined and forwarded Further assessment required Assessment complete

6. Assessment: Observation of patient/service user (other setting)

Classification	Operational definition	Purpose	Outcome
Mobility (gait/wheelchair) Stair climbing/descent (internal) Stair climbing/descent (external) Chair transfer Toilet transfer Productivity Leisure Cognitive assessment Perceptual	Assessment to establish the patient/service user's functional abilities/limitations with or without equipment	Determine patient/service user 's eligibility for service. Determine patient/service user's functional status. Determine service intervention objectives Determine patient/service user's formal and informal support network	Service referral accepted Service referral declined-NFA Service referral declined and forwarded Further assessment required

assessment Sensory assessment Biomechanical assessment Physical Environment assessment Social environment assessment Risk Other		Determine suitability of other environment Follow- up/review	Assessment complete
---	--	---	---------------------

7. Assessment: Observation of environment only

Classification	Operational definition	Purpose	Outcome
Physical environment assessment	Identification of physical barriers to independence and consider potential adaptations to meet the needs of a specific patient/service user	Determine suitability of home environment Determine suitability of other environment	Further assessment required Assessment complete

Intervention- Operational Definitions

Classification

- **Rehabilitation –ADL/selfcare.** Occupational therapy intervention aimed to restore a patient/service user's skills/capacity to undertake activities of daily living e.g transfers and personal self care tasks e.g dressing, washing, toileting etc.
- **Rehabilitation- work/productivity.** Occupational therapy intervention aimed to restore a patient/service user's skills/capacity to undertake extended activities of daily living associated with life roles e.g. parenting, grandparenting, housework, vocational interests/responsibilities.
- **Rehabilitation – leisure.** Occupational therapy intervention aimed to restore a patient/service user's skills/capacity to undertake leisure activities
- **Rehabilitation – remedial.** Occupational therapy intervention aimed to restore a patient/service user's physical, sensory, cognitive and/or psychosocial function through a graded programme of remedial activity.
- **Social environment: carer facilitation** (informal). Supporting and engaging carers in the productive interaction with the patient/service user; in efforts to promote the rehabilitative approach and/or to ease the caring role.
- **Social environment: carer facilitation.** (formal). Supporting and engaging carers in the productive interaction with the patient/service user; in efforts to promote the rehabilitative approach and/or to ease the caring role
- **Physical environment: equipment provision.** The prescription of equipment to compensate for identified functional dysfunction and address environmental barriers or to facilitate the rehabilitation process.

- **Physical environment: adaptation provision.** The prescription of adaptation to compensate for identified functional dysfunction and address environmental barriers or to facilitate the rehabilitation process
- **Referral onto other services.** Transferring part or whole of service responsibility to meet an identified need to another service.

Method

- **Teach alternative techniques.** Compensatory intervention approach which equips a patient/service user with alternative methods to undertake activities of daily living
- **Graded activity.** Occupational therapy approach to methodically pitch an activity at a level which promotes the incremental development of a patient/service user's functional ability
- **Habituation.** Method to learn/return activity patterns through a programme of practice.
- **Equipment provision –direct.** The prescription that leads to the direct provision of equipment to the patient/service user without the involvement of another party in the reassessment and prescription of the equipment. The action of “referring on” to another party to deliver the equipment falls within this operational definition
- **Equipment provision –refer on.** Action that requests intervention of other services to assess , prescribe and/or provide equipment on behalf of a specific patient/service user.(other than those listed in the “intervention” sub-categories)
- **Equipment demo.** Active demonstration of equipment to patient/service user and/or carer
- **Equipment removal.** Direct (occupational therapy practice personnel) or indirect (another party e.g. technician) action to remove previously supplied equipment to the patient/service user.
- **Adaptation provision-direct.** The prescription that leads to the direct provision of an adaptation(s) to the patient/service user without the involvement of another party in the reassessment and prescription of the adaptation(s). The action of “referring on” to another party to install/commission (e.g. technician/admin) the adaptation falls within this operational definition
- **Adaptation provision – refer on.** Action that requests intervention of other services to provide an adaptation(s) on behalf of a specific patient/service user e.g. Housing Association.
- **Adaptation-demo.** Active demonstration of adaptation(s) to patient/service user and/or carer
- **Adaptation-removal.** Action in the instruction/commissioning of the removal of the adaptation.
- **Referring onto O.T service (Health).** Requesting/transferring part or whole of service responsibility to meet an identified need to another NHS occupational therapy service.
- **Referring onto O.T service (Local Authority).** Transferring part or whole of service responsibility to meet an identified need to the South Lanarkshire Council occupational therapy service
- **Referring on (Homecare).** Service request made on behalf of the patient/service user for homecare/personal support services. Services can be statutory or private services secured through South Lanarkshire Council.

- **Referring on (Nursing)).** Service request made on behalf of the patient/service user for nursing services.
- **Referring on (other Health service)** Service request made on behalf of the patient/service user for any other NHS service.
- **Referring on (other Local Authority)** Service request made on behalf of the patient/service user for any other South Lanarkshire Council service.

Purpose

- **Increase independence.** Occupational therapy intervention aims to increase patient/service user's levels of independence in activities of daily living
- **Maintain levels of independence.** Occupational therapy intervention aims to maintain a patient/service user's levels of independence in activities of daily living
- **Support caring situation.** Occupational therapy intervention aims to ease the caring situation
- **Reduce risk.** Occupational therapy intervention aims to eradicate/minimise risks experienced by the patient/ service user and/or carer

Outcome

- **Intervention complete.** Occupational therapy service intervention with patient/service user completed. No further direct or indirect action required
- **Intervention to continue.** Occupational therapy service intervention with patient/service user incomplete. Further direct and/or indirect action required

Working Examples

1. Intervention: Rehabilitation-ADL Selfcare

Intervention: Rehabilitation ADL Selfcare				
Classification	Operational definition	Method	Purpose	Outcome
Rehabilitation-ADL/ Selfcare	Occupational therapy intervention aimed to restore a patient/service user's skills/capacity to undertake activities of daily living e.g transfers and personal self care tasks e.g dressing, washing, toileting etc	Teach alternative techniques	Increase independence	Intervention completed
		Graded activity		
		Habituation	Maintain levels of independence	Intervention to continue
		Carer facilitation		
		Equipment provision- direct	Reduce risk	
		Equipment provision –refer on		
		Equipment –demo		
		Equipment – removal		

		Adaptations provision – direct		
		Adaptations provision-refer on		
		Adaptations – demo		
		Adaptations-removal		
		Referring onto O.T service (Health)		
		Referring onto O.T (Local Authority)		
		Referring on (other Health Service)		

2. Intervention: Rehabilitation-Productivity (Physical and Social Environment)

Classification	Operational definition	Method	Purpose	Outcome
Rehabilitation-productivity	Occupational therapy intervention aimed to restore a patient/service user's skills/capacity to undertake extended activities of daily living associated with life roles e.g. parenting, grand parenting, housework, vocational interests/responsibilities.	Teach alternative techniques Graded activity Habituation Carer facilitation (informal) Carer facilitation (formal) Referring onto O.T. service (Health) Referring on (other Health services) Equipment provision- direct Equipment provision –refer on Equipment –demo	Increase independence Maintain levels of independence	Intervention completed Intervention to continue

		Equipment – removal		
		Adaptations provision – direct		
		Adaptations provision-refer on		
		Adaptations –demo		
		Adaptations-removal		
		Referring onto O.T (Local Authority		

3. Intervention: Rehabilitation –Leisure (Physical and Social Environment)

Classification	Operational definition	Method	Purpose	Outcome
Rehabilitation-Leisure	Occupational therapy intervention aimed to restore a patient/service user's skills/capacity to undertake leisure activities	<p>Teach alternative techniques</p> <p>Graded activity</p> <p>Habituation</p> <p>Carer facilitation (informal)</p> <p>Carer facilitation (formal)</p> <p>Equipment provision- direct</p> <p>Equipment provision –refer on</p> <p>Equipment – demo</p> <p>Equipment – removal</p> <p>Adaptations provision – direct</p> <p>Adaptations provision-refer on</p>	<p>Increase independence</p> <p>Maintain levels of independence</p> <p>Reduce risk</p>	<p>Intervention completed</p> <p>Intervention to continue</p>

		Adaptations – demo		
		Adaptations-removal		
		Referring onto O.T service (Health)		
		Referring onto O.T (Local Authority)		
		Referring on (Homecare)		
		Referring on (Nursing)		
		Referring on (other Health Service)		
		Referring on (other Local Authority service)		

4. Intervention: Rehabilitation-remedial

Classification	Operational definition	Method	Purpose	Outcome
Rehabilitation-remedial	O.T. intervention aimed to restore a patient/service user's physical, sensory, cognitive and/or psychosocial function through a graded programme of remedial activity.	Teach alternative techniques Graded activity Habituation Carer facilitation Referring onto O.T. service (Health) Referring on (other Health services)	Increase independence Maintain levels of independence	Intervention completed Intervention to continue

5. Intervention: Physical Environment: Equipment provision

Classification	Operational definition	Method	Purpose	Outcome
----------------	------------------------	--------	---------	---------

1.5. Equipment provision	The prescription of equipment to compensate for identified functional dysfunction and address environmental barriers or to facilitate the rehabilitation process.	Equipment provision- direct	Increase independence	Intervention completed
		Equipment provision –refer on	Maintain independence	Intervention to continue
		Equipment –demo		
		Equipment – removal	Supporting the caring situation	
		Referring onto O.T (Local Authority) Referring on (Nursing)	Reduce risk	
		Referring on (other Health Service) Referring on (other Local Authority service)		

6. Intervention: Physical environment: Adaptation provision

Classification	Operational definition	Method	Purpose	Outcome
1.6. Adaptations provision	The prescription of adaptation to compensate for identified functional dysfunction and address environmental barriers or to facilitate the rehabilitation process	Adaptations provision – direct	Increase independence	Intervention completed
		Adaptations provision-refer on	Maintain independence	Intervention to continue
		Adaptations –demo		
		Adaptations-removal	Supporting the caring situation	
		Referring onto O.T (Local Authority) Referring on (other Local Authority service)	Reduce risk	

7. Intervention: Referral onto other services

Classification	Operational definition	Method	Purpose	Outcome
Referral onto	Transferring	Equipment	Increase	Intervention

other services	part or whole of service responsibility to meet an identified need to another service	provision –refer on Adaptations provision-refer on Referring onto O.T service (Health) Referring onto O.T (Local Authority) Referring on (Homecare) Referring on (Nursing) Referring on (other Health Service) Referring on (other Local Authority service)	independ- ence Maintain independ- ence Supporting the caring situation Reduce risk	completed Intervention to continue
-----------------------	---	--	---	---------------------------------------

Travel: Operational definitions

Classification

- **Patient/service user's home.** Patient/service user's normal place of residence
- **Workplace.** Occupational therapy personnel's contracted work base and employing authority's office sites.
- **Equipment store.** South Lanarkshire Council equipment store
- **Extended ADL sites⁷⁵.** Any site other than the patient/service user's immediate home environment. The patient/service user's garden should be considered as an extended ADL. Occupational therapy intervention associated with external steps/stairs can be considered as extended ADL if the purpose of the intervention is to promote social inclusion/purposeful activity outwith the immediate home environment
- **Showrooms.** Commercial outlets which display and demonstrate specialist equipment
- **Other.** Any other site occupational therapy personnel travel to in order to undertake the duties/remit of the service.

Purpose

- **Travel to/between work bases.** Purpose of journey is to travel to and/or transfer from one workplace site to another.
- **Travel to/between community practice sites.** Purpose of journey is to travel to and/or transfer from one community based practice site to another
- **Home assessment.** Purpose of journey is to undertake an assessment of the patient/service user within their normal place of residence/home

⁷⁵ ADL: Activities of daily living

environment

- **Environmental assessment.** Purpose of journey is to undertake an assessment of the patient/service user's home in the absence of the patient/ service user.
- **Extended ADL site visit.** Purpose of journey is to undertake an assessment of the patient/service user's extended ADL community environment(s) e.g. work, leisure, in the absence of the patient/service user.
- **Extended ADL site assessment.** . Purpose of journey is to undertake an assessment of the patient/service user's in their extended ADL community environment(s) e.g. work, leisure.
- **Equipment delivery.** The purpose of the journey is to deliver equipment to the patient/service user's home or extended ADL site, or to return the equipment back to the equipment store
- **Equipment pick-up** The purpose of the journey is to pick-up equipment either from the store or the patient/service user's home/extended ADL site
- **Equipment trial.** The purpose of the journey is to provide an opportunity for the patient/service user and/or carer to "try" equipment. A trial includes a demonstration, but extends to the patient/service user/ and /or carer applying the methods demonstrated. This task can be undertaken at a range of sites including the service user's home, extended ADL site or showroom.
- **Equipment fitting.** The purpose of the journey is to install/fit equipment into the patient/service user's home or extended ADL site.
- **Equipment demonstration.** The purpose of the journey is to demonstrate the use of equipment only. The patient/service user and/or carer do not practise the methods demonstrated.
- **Adaptations trial.** The purpose of the journey is to provide an opportunity for the patient/service user and/or carer to "try" adaptations. A trial includes a demonstration, but extends to the patient/service user/ and /or carer applying the methods demonstrated. This task can be undertaken at a range of sites including the service user's home, extended ADL site or showroom
- **Home based rehabilitation –self care.** The purpose of the journey is to undertake a selfcare rehabilitation programme within the patient/service user's home environment
- **Home based rehabilitation- remedial.** The purpose of the journey is to undertake a remedial rehabilitation programme within the patient/service user's home environment
- **Community based rehabilitation- work/productivity-** The purpose of the journey is to undertake a rehabilitation programme focusing on work and/or productivity dimensions of the patient/service user's life within their extended community environment(s).
- **Home based habituation.** The purpose of the journey is to undertake a programme of practise with the patient/ service user within their home environment.
- **Extended ADL rehabilitation.** The purpose of the journey is to undertake a rehabilitation programme within the patient/service user's extended community environment(s) e.g. work, leisure, life role
- **Extended ADL habituation.** The purpose of the journey is to undertake a programme of practice within the patient/service user's extended

- community environment(s) e.g. work, leisure, life role
- **Meetings.** The purpose of the journey is to attend a meeting, briefing, supervision, case review, irrespective of venue
- **Courses.** The purpose of the journey is to attend an event such as a course or seminar,
- the primary function of which is continued professional development.
- **Check visit.** The purpose of the journey is to check any component of the occupational therapy intervention within the patient/service user's home or extended community environments.

Outcome

- **Destination reached and purpose fulfilled.** Both the journey to the intended destination and the purpose of the journey are successfully completed.
- **Destination reached/purpose not completed.** The journey to the intended destination is successfully completed, but the intended purpose of the journey is not successfully completed. This category should be selected if the purpose of the journey is only partially completed and requires further action as a result e.g. patient/service user tired. This category should not be selected if the "purpose" is only partially completed as a result of change(s) in circumstances e.g. further C.V.A.
- **Destination not reached.** Intended destination is not reached and purpose of scheduled visit incomplete

Working Examples

1. Travel: Patient/Service user's home

Category	Operational definition	Purpose	Outcome
Patient/Service user's home	Patient/service user's normal place of residence	Travel to/between community practice sites	Destination reached/purpose fulfilled
		Home visits	Destination reached/purpose not completed
		Environmental assessments	Destination not reached.
		Equipment delivery	
		Equipment pick up	
		Equipment trial	
		Equipment fitting	
		Equipment demonstration	
		Adaptations trial	
		Home based rehabilitation-self care	

		Home based rehabilitation-remedial	
		Home based rehabilitation – work /productivity	
		Home based –habituation	
		Meetings/case review	
		Check visits	

2. Travel: Workplace

Category	Operational definition	Purpose	Outcome
1.6. Workplace	Occupational therapy personnel's contracted work base, employing authority's office sites and community bases where occupational therapy services are delivered.	<p>Travel to/ between work bases</p> <p>Equipment delivery (office site other than equipment store)</p> <p>Equipment pick up (office site other than equipment store)</p> <p>Meetings/briefings/ Supervision or case review (not in service user's home).</p>	<p>Destination reached/purpose fulfilled</p> <p>Destination reached/purpose not completed</p> <p>Destination not reached</p>

3. Travel: Equipment Store

Category	Operational definition	Purpose	Outcome
----------	------------------------	---------	---------

1.7. Equipment Store	South Lanarkshire Council equipment store	Travel to/between work bases	Destination reached/purpose fulfilled
		Equipment delivery	
		Equipment pick- up	Destination reached/purpose not completed
		Equipment - demonstration	Destination not reached

4. Travel: Extended ADL sites

Category	Operational definitions	Purpose	Outcome
1.8. Extended ADL sites	Any site other than the patient/service user's immediate home environment. The patient/service user's garden should be considered as an extended ADL. Occupational therapy intervention associated with external steps/stairs can be considered as extended ADL if the purpose of the intervention is to promote social inclusion/purposeful activity outwith the immediate home environment	Travel to/between practice sites	Destination reached/purpose fulfilled
		Extended ADL site visit	Destination reached/purpose not completed
		Extended ADL site assessment	Destination not reached
		Equipment delivery	
		Equipment pick up	
		Equipment trial	
		Equipment fitting	
		Equipment demonstration	
		Adaptation demonstration	
		Adaptation trial	
		Community based rehabilitation-work/productivity	

5. Travel: Showrooms

Category	Operational definitions	Purpose	Outcome
Showrooms	Commercial outlets which display and demonstrate specialist equipment	Travel to/between practice sites	Destination reached/purpose fulfilled
		Equipment trial	Destination reached/purpose not completed
		Equipment demonstration	
		Adaptation trial	Destination not reached
		Adaptation demonstration	

6. Travel: other

Category	Operational definitions	Purpose	Outcome
Travel: other	Any other site occupational therapy personnel travel to in order to undertake the duties/remit of the service.	Travel to/between work bases	Destination reached/purpose fulfilled
		Travel to/between community practice sites	Destination reached/purpose not completed
		Home visits	Destination not reached
		Environmental assessments	
		Extended ADL site visits	
		Extended ADL site assessments	
		Equipment delivery	
		Equipment pick up	
		Equipment trial	
		Equipment fitting	
		Equipment demonstration	
		Adaptations trial	
		Home based rehabilitation-self	

		care	
		Home based rehabilitation-remedial	
		Home based rehabilitation – work /productivity	
		Home based – habituation	
		Meetings/case review	
		Check visits	

Meetings/Consultation/CPD –Operational definitions

Classifications

- **Briefing.** Meeting convened with the primary function of disseminating pre-set information to personnel. The focus for O.T. personnel is to gather Information, with limited opportunity to share information to influence briefing content.
- **Meeting.** Any gathering where the primary function is to gather and share information to jointly determine a course of action or agreement
- **Ward round.** A multidisciplinary assembly of personnel, led by a medical consultant in a ward setting with the primary function of reviewing patient's progress and to determine future intervention plans
- **Supervision.** A meeting between an employee (employees) and their line manager to review workload, appraise performance, identify training needs and obtain support and guidance.
- **Duty.** A pre-set period within working week, dedicated to responding to direct public enquiries about occupational therapy services.
- **Case Review.** A multidisciplinary meeting with the patient/service user and/or carers in attendance to review the continued relevance of a care package being provided.
- **Course.** An event attended where the primary function is personal continued professional development.
- **Peer consultation** Informal practice related discussion between peers to inform workload management and activity.
- **Lunch/ Coffee breaks.** Contractual breaks from work activity to meet employment regulations. Consuming lunch and beverages whilst undertaking work activities does not constitute a lunch or coffee break. The activities observed during these periods should be reflected within the other categories listed as appropriate.
- **“Down time”** Breaks from work activity outwith the contracted lunch and coffee break periods.

Purpose

- **Information gathering/sharing (operational/clinical).** The primary intent is to elicit and/or provide key operational and/or clinical information that will

influence both occupational therapy service intervention and the extended multidisciplinary team activity, to a patient/service user and/or carers

- **Information gathering/sharing (patient/service user).** The primary intent is to elicit and/or provide key information from/to the patient/service user that will influence/direct occupational therapy service activity.
- **Information gathering/sharing (carer)** The primary intent of the action is to elicit and/or provide key information from/to the informal carer that will influence/direct occupational therapy service activity to the patient/service user and/or carer.
- **Information gathering/sharing (system/organisational).** The primary intent is to elicit and provide organisational and policy related information that determines/influences the occupational therapy service and extended service infrastructures for service delivery.
- **Service development.** The primary intent is to contribute to a shared agenda of service development within a specific area of service
- **Continued professional development.** The primary intent is to engage in personal professional learning and development in part fulfilment of state registration
- **Professional support and direction.** The primary intent is to provide support and direction on workload management, practice and continued professional development.
- **Peer support.** Informal and formal support and direction from peers in respect to practice related matters
- **Other.** Any other purpose arising from the “Meetings/Consultation/CPD” classifications not reflected within the above listed categories

Outcome

- **No further action.** The classification task in itself is complete, as the agenda items specific to the task episode were realised and no further action to address outstanding agenda items is required. N.B. This does not reflect the completion status of the overall intervention/plan either to the patient/service user, carer, employee or service.
- **Further action.** The classification task is not complete as further action is required to address outstanding agenda items specific to the task episode.

Working Examples

1. Meeting/Consultation/CPD: Briefing

Category	Operational definitions	Purpose	Outcome
Briefing	Meeting convened with the primary function of disseminating information to personnel.	Information gathering/sharing (system/organisational)	No further action Further Action

2. Meeting/Consultation/CPD: Meeting

Category	Operational definitions	Purpose	Outcome
----------	-------------------------	---------	---------

Meeting	Any gathering where the primary function is to gather and share information to jointly determine a course of action or agreement	Information gathering/sharing (operational/clinical)	No further action
		Information gathering/sharing (patient/service user)	Further Action
		Information gathering/sharing (carer)	
		Information gathering/sharing (system/organisational)	
		Service development	
		Peer support	

3. Meeting/Consultation/CPD: Ward round

Category	Operational definitions	Purpose	Outcome
Ward round	A multidisciplinary assembly of personnel, led by a medical consultant within a ward setting with the primary function of reviewing patient's progress and to determine future intervention plans	Information gathering/sharing (clinical/operational)	No further action
		Information gathering/sharing (system/organisational)	Further Action
		Peer support	

4. Meeting/Consultation/CPD: Supervision

Category	Operational definitions	Purpose	Outcome
Supervision	A meeting between an employee (employees) and their line manager to review workload, appraise performance, identify training needs and obtain support and guidance.	Information gathering/sharing (clinical/operational)	No further action
		Information gathering/sharing (system/organisational)	Further Action
		Continued professional development	
		Professional support and direction	

--	--	--	--

5. Meeting/Consultation/CPD: Duty

Category	Operational definitions	Purpose	Outcome
Duty	A pre-set period within working week, dedicated to responding to direct public enquiries about occupational therapy services	Information gathering/sharing (clinical/operational) Information gathering/sharing (patient/service user) Information gathering/sharing (carer)	No further action Further Action

6. Meeting/Consultation/CPD: Case Review

Category	Operational definitions	Purpose	Outcome
Case Review	A multidisciplinary meeting with the patient/service user and/or carers in attendance to review the continued relevance of a care package being provided	Information gathering/sharing (clinical/operational) Information gathering/sharing (patient/service user) Information gathering/sharing (carer) Professional support and direction	No further action Further Action

7. Meeting/Consultation/CPD: Course

Category	Operational definitions	Purpose	Outcome
Course	An event attended where the primary function is personal continued professional development	Continued professional development Professional support and direction	No further action Further Action

8. Meeting/Consultation/CPD: Peer consultation

Category	Operational definitions	Purpose	Outcome
Peer consultation	Informal practice related discussion between peers to inform workload management and activity	Information gathering/sharing (clinical/operational) Information gathering/sharing (system/organisational) Peer support Continued professional development Professional support and direction	No further action Further Action

9. Meeting/Consultation/CPD: Lunch /Coffee breaks

Category	Operational definitions	Purpose	Outcome
Lunch/Coffee breaks	Contractual breaks from work activity to meet employment regulations.	1.9. Other	No further action Further Action

10. Meeting/Consultation/CPD: “Down time”

Category	Operational definitions	Purpose	Outcome
“Down time”	Breaks from work activity outwith the contracted lunch and coffee break periods.	Other	

EK/ HGH Pilot Semi-Structured Interview Schedule

Background

1. Can you briefly describe the nature of the service you currently work in?
2. Can you define your role within your current service?
3. What key outcomes do patients/service users get from your current service?
4. What are the key components that facilitate these service user/patient outcomes?
5. What restricts/limits the realisation of patient/service user outcomes within existing services?
6. Would you pay for the service you currently provide and why?

Pilot Experience

In-reach/Outreach

7. Can you describe the test cases you completed?
8. Were there any benefits to those patients/service users who experienced the test case service pathway – If “yes” what were they?
9. What was your experience of the test cases?
 - Impact on therapeutic relationship with patient/service user
 - Impact on professional role
 - Impact on service delivery
 - Impact in multidisciplinary working
 - Impact on joint working (including extended access to resources)
10. What was your experience of the management arrangements?
 - Allocation
 - Supervision
 - Case management
 - Closure
11. What supported you to engage with test cases?
12. What were the barriers to engaging with test cases?

MBI /MoHOST/Documentation

13. How have you found the use of the MBI/ MoHOST in engaging patients/service users in the assessment process?
 - a. in practice generally?
 - b. in specific relation to test cases?
14. How have you found the use of the MBI/ MoHOST in documenting and communicating patient/service user data to other services
 - a. in practice generally?
 - b. in specific relation to test cases?
15. How have you found the use of the MBI/ MoHOST in obtaining patient/service user data from other services
 - a. in practice generally?
 - b. in specific relation to test cases?

(Health Only)

16. How useful have you found having access to SWIS in obtaining or/and providing patient/service user data
 - a. in practice generally?
 - b. in specific relation to test cases?

(SLC Only)

17. What was your experience of NHS service arrangements during your test cases?
 - Documentation,
 - Ward/Clinics

Outcomes/ Reflections

18. On review of the test case experience has it made you think differently about your practice? Explain
19. On review of the test case experience has it made you think differently about other O.T service practice? Explain
20. Consider your role within current services and your test case experience, what aspects of your role do you feel provides the biggest impact for service users and why?
21. Would you pay for the service provided by you in the test case(s)and why?
22. Overall, What has been your key learning (positives/negatives) from the SWITCH pilot experience?

Future

23. What elements, if any, of the SWITCH partnership would you like to continue to develop and why?
24. Considering the Rehabilitation Framework and other policy initiatives how do you think OT services across health and social work should develop?

SWITCH Partnership

CONSENT FORM

Focus Group

The following form is for practitioners to give their consent to participate in a focus group to explore the use of the MBI/ MOHOST in practice

	Statement	Please initial box that you have read & agreed each statement
1.	I confirm that I have read and understand the information sheet for the focus group. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care and/or legal rights being affected.	
3.	I agree to take part in the above study.	

Name of practitioner

Date

Signature

Researcher

Date

Signature

When completed consent will be kept in a locked cupboard.



Interview Transcript


Interview: COE 1

Date: 06.05.10

Duration: 1hr 2 mins 36 secs

Appendix 6

Key: Focus of service

Driver for service 

Background: Questions 1-6

Q1

Can you briefly describe the nature of the service you currently work in?

COE1

I work in two of the care of the elderly wards...um...working with the...um... with the frail elderly who have multifactorial conditions....it's Acute care of the elderly **assessment** and **rehabilitation**

Comment [N4]: Link to Assessment and Rehabilitation subcategories

Q1(cont)

And how would you describe the service approach, do you feel it...it is person-centred or do you feel it is driven by organisational priorities?

COE1

No, I think it is quite **personalised**...though there is a priority in getting people (patients) discharged ...so a bit of **both** I suppose.

Comment [N5]: Response indicates that services are both person centred and organisationally driven – link to both subcategories

Key: Primary Role Description 

Q2

Ok thanks..now how would you describe your role within that service?

COE1

Mmm ..ok I, I currently **manage** **two** wards ...there is an OT and an assistant in one of the wards and a senior in the other

Comment [N6]: Management subcategory

Q2 (cont)

What about your role in terms of OT...could you describe that?

COE1

Oh yeah ...as an OT, my role is **providing** **rehab**, facilitating patient independence within the NHS and **ultimately** **discharge planning** for home

Comment [N7]: Rehab subcategory

Comment [N8]: Discharge Planning subcategory

Q2 (cont)

Can I ask you to expand a little on what you do in terms of the discharge plan?

COE1

I **liaise with different agencies**.....a lot of consultation and **communication with others** to plan and get things in place for the discharge....really just about whatever is required to....well... facilitate a **safe** discharge.

Comment [N9]: Response infers "referring on" activity

Key: Service Outcome

Q3

What do you think are the key outcomes from the service provided from yourself?

COE1

The key outcomes...patients probably gain a lot more independence, usually discharge home with equipment or adaptations... sometimes it's to more sheltered environments

Comment [N10]: Outwith service

Key: Service Facilitators

Q4

What components of the current OT service do you think facilitate these patient outcomes?

COE 1

Probably good communication and interpersonal skills....good therapeutic relations with the patient and relatives as well

Comment [N11]: Both link to interpersonal skills subcategory

Q4 (cont)

In terms of discharge, what components facilitate patients to achieve their outcomes?

COE1

Equipment provision....and OT referral quite often (to other OT services) facilitate discharges

Comment [N12]: Outwith service

Q5

Ok thanksWhat in your experience restricts or limits the realisation of patient outcomes within existing service arrangements?

COE1

Time.

Comment [N13]: Time subcategory

Q5 (cont)

Can you describe what things you think don't get achieved because of time?

COE1

Probablymmm...sometimes it feels like quite a quick turnover of patients, sometimes there is more assessment and discharge rather than rehab

Comment [N14]: Outline of impact of time restrictions on patient care-but no further explanation as to reasons why

Q5 (cont)

Do you think that those patients get rehab in the community?

COE1

Not always. Sometimes it's a missed opportunity....and sometimes, well, it is possible it's the wrong people (patients) that are referred for rehab out of here... or/and the wrong time... it's maybe not a complex discharge and it doesn't need to be referred onor it is a complex discharge but the timing is not right

Comment [N15]: Inappropriate referrals subcategory

Q5 (cont)

If it was a complex discharge, what is it that determines it as a complex discharge?

COE1

Sometimes it can be family conflict... complicates matters ...or environmental things that are not easily achieved with a one off visits....I mean some aids and adaptations require time ...but sometimes, well sometimes the expectation is that it will all be immediate ...not always possible ...needs time to organise .

Comment [N16]: Linked to relatives subcategory

Comment [N17]: Link to patient motivation/expectation

Q5 (cont)

Anything else you think can restrict patient outcomes?

COE1

From a patient point of view ...motivation.

Comment [N18]: Link to patient motivation/expectation subcategory

Q5 (cont)

So that can be a challenge to achieve patient outcomes?

COE1

Yeah...it can do...probably restricts the therapeutic relationship, If time is needed and there is a quick turnover within service, then motivation can go.....you can't build up the relationship if the motivation is not there....or there are cognitive issues with the patient...things like that

Key: Willingness to Pay Concept

Q6

This question is about the value you think patient's place on the service you currently provide...It is not that we would ask the patient to pay ...it is a health economics term to reflect the value people place on commodities ...so with this in mind ...what would you think they would be willing to pay for and why?

COE1

I think as an elderly patient... yes... there probably would be things the service could provide... I think a lot of the things we provide for example access to equipment or adaptations. I know things are means tested, but a lot of people go private just to get them, for example, stairlifts... and we can provide that in our service, yes.... would be willing to pay for an expert in that area.

Comment [N19]: Response suggests that the element of most value to patient is equipment and adaptations

Q6 (cont)

Ok ...What about the rehab side of things or would you be more willing to pay for equipment and adaptations if you were an elderly service user?

COE1

It's strange I would pay for a service in my home but I don't think I would pay for it in the ward, I think it should be paid for in the NHS.....If it was going to improve my quality of life, then I may pay for it... if it would improve my general safety

Comment [N20]: Willingness to pay reflects a greater value on home based rehab – acknowledgement of value placed on model of service aligned to service redesign aspiration/policy context – shifting the balance of care

Pilot Experience:

Key: In-reach/Outreach

Q 7

Moving onto the in-reach/outreach pilot experience, can you describe the test cases you were involved in... how many did you do?

COE1

3... overall they weren't successful because 1 patient died.... and the other 2 did not really need ongoing rehab. X came into hospital and went home, then was readmitted again quite quickly and virtually passed away. I think it was 2 visits at the house.... there wasn't a huge involvement from ongoing rehab...one patient got ongoing transfer practice whilst the second...the focus was on kitchen practice...it was limited in what I could do...but it did feel there wasn't a change in involvement from an ongoing rehab basis... it was mostly transfers... and one was transferred onto community OT service ...they weren't motivated and didn't really need the motivation because of the family support being provided.....the transfer and kitchen practice wasn't really of any benefit... I wasn't able to carry out the discharge as I normally do.

Comment [N21]: Linked to "limited" subcategory of "Benefits to Patients" section.

Comment [N22]: Linked to "limited" subcategory of "Benefits to Patients" section.

Q 7 (cont)

Do you think that period of rehab at home was of any value?

COE1

It was interesting from my personal point of view to see... to continue rehab in the persons own home. Whether it was of much more value to the patient... as to what I was doing....I'm not too sure it was.

Comment [N23]: Linked to "limited" subcategory of "Benefits to Patients" section.

Q7 (cont)

What elements of it were you not sure of?

COE1

I don't think...eh...I didn't really feel I was doing anything anymore than generic workers were doing. I think in one of the cases it progressed more in the kitchen work, but not enough that I felt I needed to(pause) ...be involved. It involved so much more prep time to do it in the patient's home and I didn't use OT skills..... there was just a limitation of what they were able to do in their own home.

Comment [N24]: Linked to "limited" subcategory of "Benefits to Patients" section or "cost to service" section

Comment [N25]: Link to "Time" as "service constraint" or "cost to service"

Comment [N26]: Linked to "limited" subcategory of "Benefits to Patients" section.

Q7 (cont)

Was kitchen practice needed?

COE1

Probably yes....I don't know...it just slowed down a lot more at home...it was a general slow down....she probably had a purpose to what she was doing (on the ward), she was going to the toilet or was going the day room...there wasn't the same purpose at home...I think she quite enjoyed the company (hospital). Probably deteriorated (at home)...there wasn't the time to carry out any kitchen activity in the hospital. She was quite keen to go back to do her bit, but didn't have the tolerance

Comment [N27]: Linked to subcategory of "Patient motivation" in "Service Constraints" section

Comment [N28]: Linked to subcategory of "time" in "Service Constraints section"

Q7 (cont)

Ok then thank you ... can I now ask you to think about your experience in general terms and describe how you found the experience from a personal or professional perspective ...you know ...extending your role out into the community...the outreach bit...how did that feel for you?

COE 1

Yeah, it was ok ...kind of limited though...because, well ... because of the cases I had ...not too successful so my experience was sort of limited with the cases I had ...

Q7 (cont)

Did you learn anything from the experience?

Suppose working in the community gave a different perspective....new systems, processes and things like thatthat would take a bit of getting used to ...but um...but I think working in Acute services gives you a strong position to take on the extended remit ...mmm ...think there would need to be new learning...but working

Comment [N29]: Link this statement with response to question 12 and link to "skill limitation" in "in-reach/outreach" section

Comment [N30]: Link this statement with response to question 12 and link to "skill limitation" in "in-reach/outreach" section

in Acute, you have experience of both the Acute and the community side of things...you know

Key: Benefits to Patients

Q8
Yeah, yeah thank you...Can I maybe go back to the in-reach/outreach experience from a patient's perspective ...can you tell me from your experience, were there any benefits to the patients who underwent the outreach test case experience?

COE1
Yes, I think continuity was certainly an advantage for the patient.... all remembered who I was and obviously I had met the families as well, so there wasn't a problem going to the house... it wasn't another new person so continuity was quite good. Certainly good from my point of view...they knew who was coming to the house... didn't have to introduce myself or gather information...could start work straight away.

Comment [N31]: Link to C.O.C relational subsection in "Benefits to Patient" section

Comment [N32]: Link to C.O.C relational subsection in "Benefits to Patient" section

Comment [N33]: Link to C.O.C relational subsection in "Benefits to Patient" section

Comment [N34]: Link to C.O.C informational subsection in "Benefits to Patient" section

Comment [N35]: Link to C.O.C relational subsection in "Benefits to Patient" section
AND
Link to Benefits to Profession" section -sub category "CoC management and informational"

Comment [N36]: Suggests increase in level of professional satisfaction but response to direct question 9b in re to this states position

Key: Benefits to Profession/Service

Q9a
Uhuh...and what was your experience of the test case impact on the therapeutic relationships?

COE1
I think it improved because you got to work with the patient a lot longer. Previously didn't get the chance to build up that relationship....it was more personal to them (patients)...it was more I think ...it was more emotional things, they (patient) wanted to talk more about relationships, about therapy... I think a lot of it was more possible... probably weren't aware of family dynamics and relationships to the same extent in the hospital context.

Q9b
And did the test case experience have an impact on your professional role?

COE1
Probably time away from the ward. Not many (3 test cases) so wasn't a huge impact....got a wee bit of an insight into other OT's roles and different services and paperwork etc...but didn't have a huge involvement in any adaptations so I didn't

Comment [N37]: Link to "Benefits to Profession" section -sub category "CoC relational"


Comment [N38]: Link to C.o.C informational subsection in "Benefits to Patient" section
AND
Link to C.o.C. informational subsection in "benefits to prof/service" section

Comment [N39]: Link to C.o.C relational subsection in "Benefits to Patient" section

Comment [N40]: Response suggests impact of prof role linked to structural and resource influences

Comment [N41]: Link to "to prof/service" section - "Insight to other OT services" subcategory

<p>really learn a huge amount...thought I might.</p> <p>Q9b (cont) Ok... in terms of the test cases you completed, did you experience any increased professional satisfaction?</p> <p>COE1 No. I think the patients that I had didn't really progress and plateaued.</p> <p style="text-align: right;">Key: Cost to Service</p> <p>Q9c Have you got any reflections on what the impact of the test case arrangements had on your pre-existing service arrangements...you know... what changed?</p> <p>COE1 Obviously time out of the ward setting. Service delivery...em....it was a wee bit different to coordinate...and get used to that... and recording the notes and things like that was time consuming. More involvement with generic workers, but didn't have any involvement with other OT's really apart from the initial 20 min conversation about the paperwork etc...liaised with physios really for discharge.</p> <p>Q9d What about the impact on multidisciplinary working?</p> <p>COE1 Sometimes coming back from a visit you couldn't get up to the ward...so it was a technical hitch but on the whole it was a positive experience of multidisciplinary working</p> <p>Q9e What was the impact on joint working, including access to extended resources if that was applicable?</p> <p>COE1 I would say it worked quite wellobviously had community OT's coming into the ward and sometimes that was successful and sometimes it wasn't.</p> <p>Q9e (cont) What was your experience of that?</p> <p>COE1 Well, probably when the community OT's came in I wasn't here so it wasn't that good a handover....or a good time for her to be here so she probably didn't get what was needed. I probably would have liked more time with the community OT to go over different protocols and things like that.</p> <p>Q9e (cont) Anything in particular?</p> <p>COE1</p>	<p>Comment [N42]: Response in the negative despite positive statements suggesting improvements in therapeutic relations in Q9a</p> <p>Comment [N43]: Link to "cost to service"</p> <p>Comment [N44]: Statement in support of reason it took more time – link to In-reach/Outreach section – Skill limitation subcategory (link to previous statements noted)</p> <p>Comment [N45]: Statement in support of reason it took more time</p> <p>Comment [N46]: Link to intra org MDTcontext or inter-organisational context?</p> <p>Comment [N47]: Link to "Cost to Service" section – not involved in "MDT subsection"</p> <p>Comment [N48]: Response infers a "cost to service" – "inter-service relations" – but statement indicate both positive and negative experience, with leaning toward positive</p> <p>Comment [N49]: Supplementary statement to "In-reach/Outreach" section sub category "skill limitation"</p>
---	--

<p>Possibly the routine, the communication network...just in general....general things that happen on the ward...the equipment on the ward ...more time to relax and get used to that...feel more at home in the ward setting. I don't know how you get round that</p> <p>Q9e (cont) Do you think it would be less of a challenge for the ESDT OT colleagues?</p> <p>COE1 mmm... no not really ...easier for hospital OT's who are used to going out in the community...I would normally do an environmental home visit ...but they're (EDST OT) not used to working on the ward.</p> <p>Q9e (cont) What was your experience in relation to accessing an extended range of resources?</p> <p>COE1 I didn't really get an opportunity to access the extended range of resources within the test cases I was involved in.</p> <p>Q9f Is there anything else in respect to joint working experience we have not covered?</p> <p>COE1 I would say there wasn't a huge amount of joint working from my point of view in respect to referrals (Acute referrals) being picked up from other OT services</p> <p>I think possibly one other thing that came up was if somebody required to transfer... that was a bit of an issue because that meant the support worker would be involved as well and it would have to be me or another OT in the hospital that would become involved again for the transfer... that wasn't ideal.</p> <p>And in respect to the communication thing again... a lot of the communication between the nurses and relatives is through the OT....and when you were at the nursing station and the nurses asked for an update it was difficult because it wasn't your patient...you had to get the OT who was responsible for the patient in question to give the update...but the nurses and medics view you as the OT allocated to the ward and expect you to know.</p>	<p>Comment [N50]: Supplementary statement to "In-reach/Outreach" section sub category "skill limitation"</p> <p>Comment [N51]: Supplementary response linked to response themes in question 7 and question 12</p> <p>Comment [N52]: Statement suggests perception that there was an absence of reciprocal arrangements required for collaborative working- link to findings in chapter 6 -literature linked</p> <p>Comment [N53]: Statement infers that service redesign generated duplicate activity – cost to service section –Impact on service delivery subsection</p> <p>Comment [N54]: Link to "cost to service"- not involved in MDT subcategory</p> <p>Comment [N55]: Link to "cost to service"- not involved in MDT subcategory</p>
<p style="text-align: right;">Key: Management measure </p> <p>Q10a OK, thank you. If I can now move on to your experience of the management arrangements. What was your perspective in respect to allocation and support structures?</p> <p>COE1 I actually found it quite weird that "x" (service coordinator) knew patients on the ward before me sometimes, but we certainly knew where they came from, what they were</p>	<p>Comment [N56]: Impact on autonomous role within pre- existing service arrangement – but not stated</p>

about and also whether they were known to anybody that was probably very helpful.

Comment [N57]: Link to “Management measure” section – “positive Support” sub category

Q10a (cont)

In terms of identifying test cases or having to put them on SWIS, how well do you think that process worked?

COE1

I felt that sometimes there was a wee bit pressure to find a patient for a test case. It maybe would have been better if it had been left to the natural progression of things ...I felt that sometimes it was a bit of a pressure to find someone to be a good test case...if that makes sense?

Comment [N58]: Link to “Management measure” section – “time pressures” sub category

Comment [N59]: Link to “Management measure” section – “positive Support” sub category

Q10b

Uhuh...In terms of what was expected of you, did you feel you had the right information, for example, about what to do, where things were going and why you were doing certain things?

COE1

Mmmm.... Yeah...I think so.

Comment [N60]: Link to “Management measure” section – “time pressures” sub category (supplementary)

Q10a (cont)

There weren't any times when you were a bit unsure of what was happening?

COE1

No

Comment [N61]: Link to “Management measure” section – “time pressures” sub category (supplementary)

Q11

Now I want to spend a bit of time to consider what you thought were the main barriers and facilitators in undertaking the in-reach/outreach practice arrangements. Firstly I would like to ask what things supported you in undertaking the test cases?

COE1

Found it was a more directive approach in the organisation that I had to do the test cases in ...directed by the systems and procedures rather than something I was fully engaged inI felt I was trying to fix somebody to have numbers and cases rather than... em...I don't know... I felt I missed out on the whole process... there wasn't a learning curve....possibly didn't look at the buddying system in order to get support in respect to what to do.... as it was easy to do... it wasn't the processes ...it was how to get involved in the organisation.

Comment [N62]: Response doesn't suggest facilitator influence – suggests process directed works but not in supportive or meaningful way for therapist – implications if not “fully engaged” for activating mechanisms that would result in meaningful change.

Comment [N63]: Acknowledgement by therapist that the experience did not alter frames of reference or expand understanding – again implications of this on achieving sustainable change in practice (Argyris and Schon)

Q12

Ok and in your experience, what were the barriers?

COE1

Comment [N64]: Acknowledgment of need to feel part of organisation structure to affect change - implications for service redesign – embed system changes that create “membership” – structural influences on competing generative mechanisms

Suitability of patients at that time... I became quite unwell. Possibly the change itself ..again something different, changing my role... I suppose being comfortable in certain areas....going into a different area, you're not in control, out your comfort zone possibly.

Comment [N65]: Acknowledgement of personal agency within change process

Comment [N66]: Link to inreach/outreach section – subcategory of “out of comfort zone”

Q12 (cont)

Anything else you want to say about the in-reach -outreach experience that's not come up in these questions?

COE1

No

MoHOST/MBI Tools: Q13-17

KEY: MoHOST **MBI**

Q13

I'm now going to ask you about how you found using the MBI and the MoHOST in practice. How did you find these standardised tools in the assessment process?

COE1

The MoHOST, as discussed before, is time consuming....it's a different language and you would need to get used to it. There is a need to share a lot of information with other people...I don't think, eh ...certainly within the hospital environment, that a lot of people would read the assessment.

Comment [N67]: Link to MoHOST section – “time consuming” subsection

Comment [N68]: Rationale as to time required

Comment [N69]: Link to MoHOST section – “not valued”

Q13(cont) /14

(answering Q14)

Do you mean within the multidisciplinary team?

COE1

Yeah...the medics and nursing staff would not be familiar with its language...it's too long and the practicalities of it didn't work in the Acute environment. In Health we have to write every day in the medical notes ...we had to write case notes, medical notes and come down and type into the computer for the MoHOST ...so actually, it took twice as long to do the paperwork.... if you like ...than before.

Comment [N70]: Link to MoHOST section – “not valued”

Comment [N71]: Rationale why the tool was not practical within Acute setting

Comment [N72]: Service redesign measure leading to duplicate activity (unintended consequence x2)

Q13 (cont)

In terms of its use in practice, do you think it had utility in terms of assessing patients in the hospital context....did you think you know the patients well enough to be able to complete the tool?

COE1

I think you could if you had an idea where the problems were in terms of what areas. ...made you look at areas you wouldn't normally have asked because you needed it to complete the assessment (documentation).... made you delve for more information than you would normally ...I mean whether physical or in terms of motivational...

Comment [N73]: Response suggest a change in practice (assessment) however response to direct question re MoHOST influencing a shift in practice was responded with an inference that it did not change practice at the intervention stage – linked to structural influences

Q13 (cont)

So did it shift your practice?

COE1

(answering

Q14)

Mmm...no time... and the MDT don't read it...within Acute services the focus is on getting patients discharged...there are key phrases that are asked for ...you know ...in relation to mobility and transfers etc

Comment [N74]: Link to MoHOST section – sub category “no affect on practice”

Comment [N75]: Link to MoHOST section – sub category “not relevant to role”

Q13 (cont)

What about the MBI...What was your experience of the MBI in practice?

COE1

The Barthel I quite like I must admit. We've used it for a while in this serviceObviously the Barthel assessment you have a baseline and you see some improvement hopefully, but I find people's score quite differently. People score very differently....even in Hairmyres ...so I might have a patient that has had a Barthel completed, but it's not the way I would score itit's quite difficult to determineI think if you control it on admission and discharge to get a proper picture that would help. The MoHOST I think ...well it's ..it's just too time consuming

Comment [N76]: Link to “MBI”section – subcategory “familiarity with tool”- confidence resulting from previous knowledge and application within existing service/organisation

Comment [N77]: Response suggests utility in practice – link to “MBI” section – sub category “utility”

Comment [N78]: Statement infers ? about inter- reliability – link to case example x

Comment [N79]: Link to MoHOST section – “time consuming” subsection (supplementary)

Q14 – answered in body Q13

Q15

Have you ever received a MBI and/or MoHOST from other services and how have you found the sharing of information?

COE1

Part of it is usually done... it's very rarely all completed and they *****
****(inaudible)

Comment [N80]: Statement (partial) infers that the data sharing is incomplete

Q15(cont)

Anything else in terms of MBI and MoHOST in terms of practice and use and how you found it generally?

COE1

As I said ...MoHOST is a bit time consuming.

Comment [N81]: Link to MoHOST section – “time consuming” subsection (supplementary)

Q15(cont)

Do you think it's a worthwhile way of spending your time?

COE1

No I think it was very time consuming.

Comment [N82]: Link to MoHOST section – “time consuming” subsection (supplementary)

Key: SSA I.T. ■

Q16

Ok thanks ...Now I am going to ask about the IT SWIS development in practice...How useful did you find having access to SWIS in terms of getting and providing information?

COE1

Probably haven't used it as fully as I could have done, but the times I did use it I thought it was very good...was able to see if patients were already in receipt of care packages and things like thatI quite liked it ...but it's not something I would use enough to get used to doing.

Comment [N83]: Link to SSA/ I.T. section – subcategory of “utility – obtaining data”

Q16 (cont)

Would you like to continue to have access to it?

COE1

Yes, but probably in relation to the documentation (MBI/MoHOST functionality) within SWIS..so much easier on computer ...that was the difference although it was slow....still had duplication between the computer and paperwork that was an ongoing issue, how did you implement that and replace it when we have 24 hours to do our notes can't do both.....

Comment [N84]: Affirmative response

Comment [N85]: Reference to duplicate activity generated by embedding service redesign within pre-existing structures – confidence to replace old with new not in situ

Q16 (interviewer)

Yeah ...it really would be important to minimise the duplication....I agree... it would not be practical to do both.

Q17 – COT only

Outcomes/Reflections: Q18-22

Q18

Ok...now I'd like to take an opportunity to spend a bit of time to recap and reflect on your experience of the service redesign.is that ok?

COE1

Yeah...that's fine

Q18 (cont)

I appreciate that the test case experience you had was limited but ... but has it made you think differently about any element of your practice?

COE1

Yes, it makes me probably more aware when completing a referral to another OT service...what they would be looking for... and their role...more aware of the stages of a patient's journey ...more aware of what will happen after they leave the hospital and the kind of timescales involved...things like that.

Q18(cont)

Has this increased awareness given you different insights to joint working opportunities?

COE1

Yeah...possibly areas for extended roles... things like information on how to go about organising stairlifts.

Comment [N86]: Response infers an increase in awareness about other services and implications of these on patient journey – only practice change reported is in reference to completing a referral – (contrary to aspiration of service redesign intent –minimise transition of patient care)

Comment [N87]: Response indicates development in thinking in terms of extending role (area identified limited impact to existing service arrangements i.e. referral to equipment store)

Q19

Has the test case experience made you think differently about other OT practice or service arrangements? Has your perception on other services changed in terms of what they do?

COE1

I don't think it's really changed my perception ...I think I had a hand on what they did anyway.

Comment [N88]: Response suggests no impact to "Cost to service" section under "inter-service relations"

Q20

Considering your role in current services and your test case experience, what aspects in your role do you feel provided the biggest difference to patients?

COE1

Building up a relationship, trust...being the key person. I feel that is certainly my role ...you have that ability to do that... and I think staff know it which helps from a communication point of view ...and patients do too.

Q20 (cont)

The fact that that stops at discharge, what do you think about that.... as it's quite a vulnerable time for a lot of patients?

COE1

A lot of the time... if I feel they are very vulnerable, I quite often do check visits, it can be simple as giving them information to contact somebody else and reassuring them re OT.... and their families etc.

Comment [N89]: Link t "Benefit to patient" section – subsection "CoC relational" (supplementary)

Comment [N90]: Link to "Benefits to prof/service" section – subsection "CoC informational" (supplementary)

Comment [N91]: Link t "Benefit to patient" section – subsection "CoC relational" (supplementary)

Comment [N92]: Response suggests that OT in exerting their "agency" (to a limited extent) within pre-service redesign service arrangements

Q21

Returning to the “Willingness To Pay” concept ...would you be willing to pay if you were a service user for the test case service arrangements that you were involved in?

COE1

In terms of the ones I've been involved in.... I don't think it made a huge difference

Q21(cont)

In principle?

COE1

Being in principle, then probably yes, I didn't have the best experience in the test cases...

Q21 (cont)

Considering the existing service arrangements and the test case redesigned service model, what would you rather pay for ...if you were a patient?

COE1

I think the concept of one therapist all the way through, somebody that I could relate to rather than chopping and changing (redesigned service)

Comment [N93]: Acknowledgement that CoC for care of the elderly is important and of value

Q 22

Overall what's been your key learning – the positive and the challenging?

COE1

A lot of ups and downs...there have been both. The positives probably joint working..things are now a bit more joined up.. but not as much as I thought I might do... but I would like to think that that will continue because of the work we have been doing because of things likes stair lifts etc. I would probably like to shadow someone through the whole process and through the paperwork, I think that's a positive thing. That's been a positive thing wanting to find out a bit moreI think I've thought about it a lot more than before.

Comment [N94]: Link to proposed action in re to In-reach/outreach section "skill limitation" subsection (Supplementary)

Q22 (cont)

Your interest's been sparked ...that's good ...what about the more challenging elements?

COE1

I thought the communication may be better ... don't think we really had that experience....communication between ourselves and other services re discharge, I felt after the initial contact that was it, I just got on with it.

Comment [N95]: Indication that service redesign sparked an interest – poss link to "Inreach/Outreach" section – subsection "Inspired"

Q22 (cont)

Can you tell me a bit more about which elements of communication were challenging?

COE1

The communication wasn't bad or good... I just felt that there was much of it that was missing... I felt I ...mmm..there was nobody there..... I thought it would be working more as part of the discharge team ...but it wasn't ...it was going away from it again.

Comment [N96]: Inference that "lone working" arrangement was a challenge to staff member who was normally an integral part of MDT. – implications for service redesign predicated on peripatetic models of care in efforts to achieve CoC through different organisational services.

Q22 (cont)

Was that the professional multidisciplinary team connection you were missing?

COE1

Yes...out in the community it's different...you were reading about what you were going into and then you were going back and phoning up the generic worker and saying I've done such and such and could you maybe go out again... anyway, it would be nice if you were part of a team meeting for this person (patient), (and agreeing) this is how we are going to structure it... but I had to go and find in the diary when the physio was going in and work out when I was going in. I felt I was working into a team... slotting in between other workers rather than working together.

Comment [N97]: Unintended consequence of uni-professional service redesign injected into pre-existing whole system

Q22(cont)

Ok ...thanks... that was helpful ...was there anything else that was different in the way you were working within the test cases?

COE1

Mmm, yeah...seeing them (patient) in a different environment, seeing them as an in- patient... its only for a half hour slot... it's nice to see people in their environment... sometimes you see things differently, it's quite hard to begin with... but... may be a couple of days after getting home, things improve...after 5/6 weeks you see how they are managing/coping.

Comment [N98]: Link to “Benefits to prof/service” section but falls short of making reference to how it would contribute to management CoC explicitly

<p>Future: Q23-24 Q23 In terms of future, what elements of the SWITCH OT service redesign,...if any... would you like to continue to develop and why?</p>	
<p>COE1 I think I would keep Barthel... but I probably didn't use it to what I could have done... I would quite like to do that and get the information that way.</p>	<p>Comment [N99]: Link to MBI section – utility subcategory (supplementary)</p>
<p>Q23 (cont) What about the MoHOST?..... Any new perspective on the potential of the MoHOST?</p>	
<p>COE1 Probably not... I don't think.... because it's not practical in the Acute sector</p>	<p>Comment [N100]: Link to MoHOST section – subsection “not valued” or “not relevant to role” (both supplementary to previous statements made in connection with this)</p>
<p>Q23 (cont) Ok...any views in respect to the SWIS IT developments or the in-reach /outreach arrangements?</p>	
<p>COE1 What following the patient through? I like the concept of it but not the reality.</p>	<p>Comment [N101]: Despite espoused value placed on CoC from both a patient perspective and a service/professional perspective – under related sections – statement made at this point suggests on balance this was not enough to extricate from pre-existing service arrangements – structural influence</p>
<p>Q23 (cont) What were the main issues?</p>	
<p>COE1 I think again it comes down to time to do thatwith the caseloads...you don't have the time so that other caseloads don't suffer. There were also difficulties with not being able to be present on the ward..... If you're not there I feel as if I'm not doing the job properly..... as I do all the notes on the ward...I like to be on the ward.</p>	<p>Comment [N102]: Link to “Service constraint “section – subsection “time”(supplementary)</p>
<p>Q23 (cont) Any thoughts on the SWIS system?</p>	<p>Comment [N103]: Rationale as to the implications of undertaking new way of working to promote patient CoC</p>
<p>COE1 SWIS sharing information backwards and forwards between services ...that's something I would keep</p>	<p>Comment [N104]: Linked to “Cost to Service” section – “not involved in MDT “sub category (supplementary)</p>
	<p>Comment [N105]: Rationale as to implications of not upholding MDT practice norms</p>
	<p>Comment [N106]: Link to SSA IT section – obtaining data was already referenced but now includes sending data – not previously identified as a strength – ? future anticipated development/aspiration</p>

Q24

OK, thank you, that's great ...could you now consider the rehab framework and other policies initiatives, how do you think OT services within Health and Social Work should develop in the future?

COE1

Ideally more joint working definitely

Comment [N107]: Joint working – link to previous statements which suggest that the aspiration is to develop interprofessional relationships – implications of definition / understanding of joint working purpose in service redesign activities /developments

Q24

What aspect would you like to see?

COE1

I think having made a referral to a community OT, getting a community OT to go out and follow through.... probably joint working with someone rather than on my own. I feel I don't have the skills to do major adaptations

Comment [N108]: Link to “In-reach/outreach” section – sub category “skill limitation” (supplementary statement – but more explicit)

Q24(cont)

Anything else you would like to say that you have not had the opportunity to say in the interview in respect to your experience of the SWITCH service redesign or where you would like things to develop?

COE1

I think I'm quite happy ... I think I've said everything

Interviewer

Well that's it....thank you for your time and participation x ...it is really appreciated.

Q24

OK, thank you, that's great ...could you now consider the rehab framework and other policies initiatives, how do you think OT services within Health and Social Work should develop in the future?

COE1

Ideally more joint working definitely

Q24

What aspect would you like to see?

COE1

I think having made a referral to a community OT, getting a community OT to go out and follow through.... probably joint working with someone rather than on my own. I feel I don't have the skills to do major adaptations

Q24(cont)

Anything else you would like to say that you have not had the opportunity to say in the interview in respect to your experience of the SWITCH service redesign or where you would like things to develop?

COE1

I think I'm quite happy ... I think I've said everything

Interviewer

Well that's it....thank you for your time and participation x ...it is really appreciated.

Themed Subcategories		Service Profile			OT Identifier: Statement Source		
		COE%	PC%	COT%	COE (n=3)	PC (n=4)	COT (n=6)
Service Focus	Assessment	33%	50%	0%	1	1,4	0
	Rehabilitation	100%	75%	0%	1,2,3	2,3,4	0
	Equip&Adapt	67%	0%	100%	2,3	0	1,3,4,5,6
		COE%	PC%	COT%	COE	PC	COT
Service Driver	Person Centred	67%	50%	67%	1,2	1,3	1,2,3,4
	Organisationally Driven	67%	100%	100%	1,3	1,2,3,4	1,2,3,4,5,6
		COE%	PC%	COT%	COE	PC	COT
Primary Role	Functional Ax	67%	0%	50%	2,3	0	3,4,5
	Discharge Planning	100%	0%	0%	1,2,3	0	0
	Referral on to/Organisin other services	67%	50%	33%	1,2	2,4	2,3
	Rehab	33%	75%	50%	1	1,2,4	2,3,6
	management	67%	25%	0%	1,3	1	0
	Equip&Adapt	0%	25%	33%	0	4	1,5
	MDT working	0%	0%	33%	0	4	2,4
		COE%	PC%	COT%	COE	PC	COT
Service Outcome	Independence	67%	25%	100%	1,2	3,2	1,2,3,4,5,6
	Discharge	33%	0%	0%	1	0	0
	Prevent admission	0%	25%	17%	0	3	3
	Building confidence	0%	25%	17%	0	2	5
	Pt Informed choice	0%	0%	33%	0	0	5
	Minimise Risk	0%	0%	67%	0	0	3,4,5,6
	Support Caring Situation	0%	0%	50%	0	0	0
	Quality of life	0%	0%	33%	0	0	0
Service Facilitator		COE%	PC%	COT%	COE	PC	COT
	Equip&Adapt	33%	25%	33%	1	2	
	Interpersonal skills	33%	25%	17%	1	3	3
	ADL Suite	33%	0%	0%	2	0	0
	Support workers	33%	0%	0%	2	0	0
	Proximity to ward	33%	0%	0%	2	0	0
	Staff skill and competence	33%	0%	50%	3	0	2,3,6
	Management &Leadership	33%	0%	50%	3	0	1,4,5
	Joint Working	33%	25%	33%	3	2	4,5
	MDT	0%	25%	17%	0	1	6
	Family	0%	25%	0%	0	2	0
	Patient motivation	0%	25%	17%	0	4	2
	Resources	33%	25%	17%	3	4	6
Service Constraints		COE%	PC%	COT%	COE	PC	COT
	Relatives	33%	0%	0%	1	0	0
	Patient Motivation/expectation	67%	25%	33%	1,3	2	2,3
	Time	100%	25%	83%	1,2,3	1	1,2,4,5,6
	Innapprop referrals	33%	0%	0%	1	0	0
	Resource limitations	33%	75%	17%	3	1,2,4	1

	Professional Resistance	33%	25%	17%	3	4	1
	Other service WL/Timescales	0%	75%	33%	0	1,2,3	1,2
	Service structures/ criteria	0%	0%	67%	0	0	3,4,5,6

Service Redesign

Experience(inreach/outreach)

In-reach/ Outreach		COE%	PC%	COT%	COE	PC	COT
	Out of comfort zone	67%	75%	50%	1,2	1,2,4	2,3,4
	New management arrangement	33%	0%	17%	3	0	1
	Inspired	0%	25%	17%	0	3	6
	Questioning current service	0%	25%	50%	0	1	3,4,5
	Skill limitation	100%	75%	17%	1,2,3	1,3,4	4

		COE%	PC%	COT%	COE	PC	COT
Benefits to Prof/Service	Duplication Avoidance	33%	0%	33%	3	0	4,5
	CoC-relational	33%	25%	83%	1	3	1,2,3,4,5
	CoC-informational	67%	25%	17%	1,3	1	3
	CoC-management	0%	0%	0%	0	0	0
	Impact on Practice	0%	0%	17%	0	0	2
	Increased prof satisfaction	67%	50%	100%	2,3	2,4	1,2,3,4,5,6
	Insight to other OT service roles	67%	75%	67%	1,3	1,2,4	1,2,4,5
	Prof Development	33%	0%	17%	2	0	1
	Reducing no of staff	0%	0%	33%	0	0	5,6

		COE%	PC%	COT%	COE	PC	COT
Cost to Service	Not involved in MDT	100%	0%	0%	1,2,3,	0	0
	Time	67%	75%	50%	1,3	1,2,3	1,3,6
	Staff stress	33%	0%	17%	3	0	1
	Interservice relations	33%	0%	33%	3	0	1,4
	Service stats/standards	0%	50%	50%	0	2,4	4,5,6
	Impact on service delivery	33%	0%	33%	1	0	1,2

		COE%	PC%	COT%	COE	PC	COT
MoHOST	Utility	0%	0%	83%	0	0	1,2,3,5,6
	Time consuming	100%	100%	50%	1,2,3	1,2,3,4	1,4,5
	Valued	0%	25%	83%		4	1,3,4,5,6
	Not valued	100%	75%	0%	1,2,3	1,2,3	0
	Not relevant to role	100%	25%	50%	1,2,3	1	3,4,6
	No affect on practice	100%	50%	0%	1,2,3	1,2	0
	Affect on practice	0%	25%	100%	0	4	1,2,3,4,5,6

		COE%	PC%	COT%	COE	PC	COT
MBI	Utility	67%	100%	83%	1,3	1,2,3,4	1,3,4,5,6
	Simple to Implement	0%	25%	33	0	4	3,6
	Not time consuming	0%	50%	0	0	3,4	0
	Familiarity with tool	67%	75%	0	1,3	1,2,3	0

	Communication efficacy	33%	50%	0	3	1,2	0
--	------------------------	-----	-----	---	---	-----	---

COE%	PC%	COT%	COE	PC	COT
33%	25%	83%	2,3	2	1,2,3,4,6
67%	75%	67%	2,3		13,4,5
67%	75%	0%	1,3	1,2,4	0

COE%	PC%	COT%	COE	PC	COT
33%	50%	17%	1	2,3	3
67%	25%	50%	2,3		2,3,5
67%	50%	17%	1,3	1,4	1
67%	50%	0%	2,3		0

COE%	PC%	COT%	COE	PC	COT
67%	75%	83%	1,2	2,3,4	2,3,4,5,6
67%	75%	50%	1,3	1,2,4	1,2,5
67%	25	17	1,3	2	1

COE%	PC%	COT%	COE	PC	COT
0%	50%	100%	0	3,4	1,2,3,4,5,6
100%	50%	0%	1,2,3	1,2	0

COE%	PC%	COT%	COE	PC	COT
33%	0%	0%	1	0	0
33%	50%	33%	1	2,4	3,6
100%	50%	50%	1,2,3	2,3	3,4,5
67%	75%	83%	1,3	1,2,3	1,3,4,5,6
33%	0%	17%	2	0	4

SL24 Project not requiring REC review
Version 2, October 2004

Lanarkshire NHS Board

14 Beckford Street
Hamilton
ML3 0TA

NHS
Lanarkshire

Telephone: 01698 281313
Fax: 01698 423134

www.nhslanarkshire.co.uk

Date: 20 September 2006
Your Ref: PC/MB

Enquiries to: Mrs. Mary Buchanan
Extension: 6317
Direct Line: 01698 206317

Ms. Nadia Ait-Hocine
Social Work Resources
Council Headquarters
Almada Street
Hamilton

Dear Ms. Ait-Hocine

**NHS LANARKSHIRE AND SOUTH LANARKSHIRE COUNCIL OLDER ADULT
OCCUPATIONAL THERAPY SERVICE REDESIGN: MEASURING UP TO A
JOINT FUTURE?**


Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

Outline of study.

These documents have been considered by the Chairman who has advised that the project is not one that is required to be ethically reviewed under the terms of the Governance Arrangements for Research Ethics Committees in the UK.

Yours sincerely,


DR. G. OFILI
CHAIRMAN


LINKLINE TO BETTER HEALTHCARE
01698 85 55 88

LAT100